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The Journal
OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XLII JULY, 1955 No. 1

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1955-56

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Claude J. Hunt

What Is Your AMA?
Elmer Hess

Surgery of the Heart and Great Vessels
DeWitt C. Daughtry

ACTH and Cortisone in the Treatment of Pulmonary Infection
Report of a Case
Louis M. Sales

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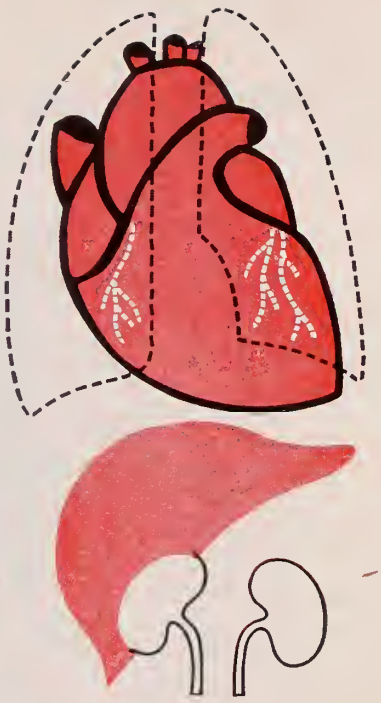
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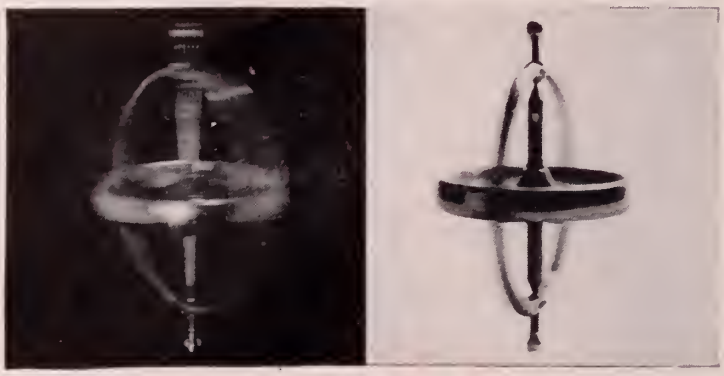
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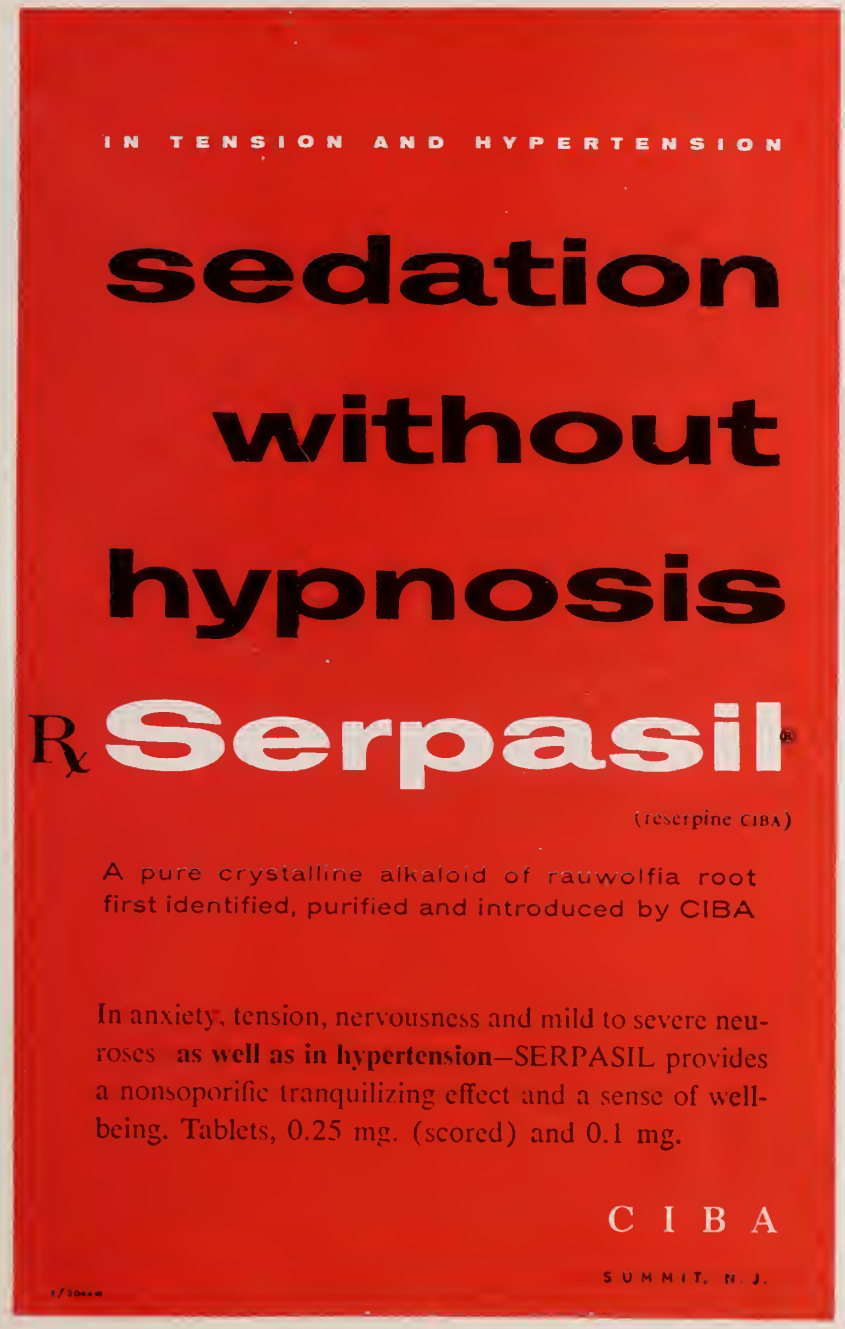
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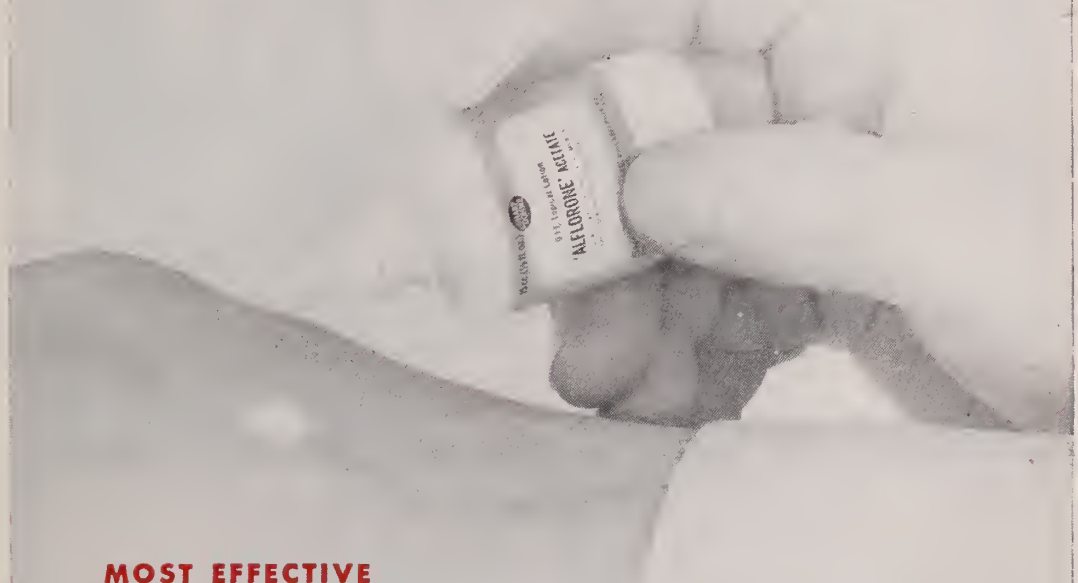
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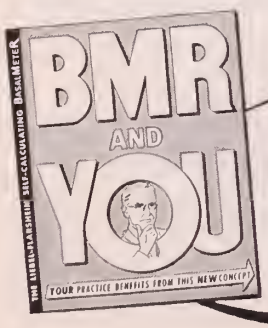


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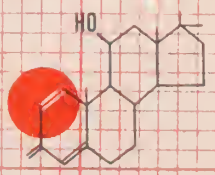
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1. Bunim, J. J., Pechet, M. M., and Bollet, A. J.: J.A.M.A. *157*:311, 1955.
2. Waine, H.: Bull. Rheumat. Dis. *5*:81, 1955.
3. Tolksdorf, S., and Perlman, P.: Fed. Proc. *14*:377, 1955.
4. Herzog, H. L., and others: Science *121*:176, 1955.
5. Dordick, J. R., and Gluck, E. J.: J.A.M.A. *158*:166, 1955.

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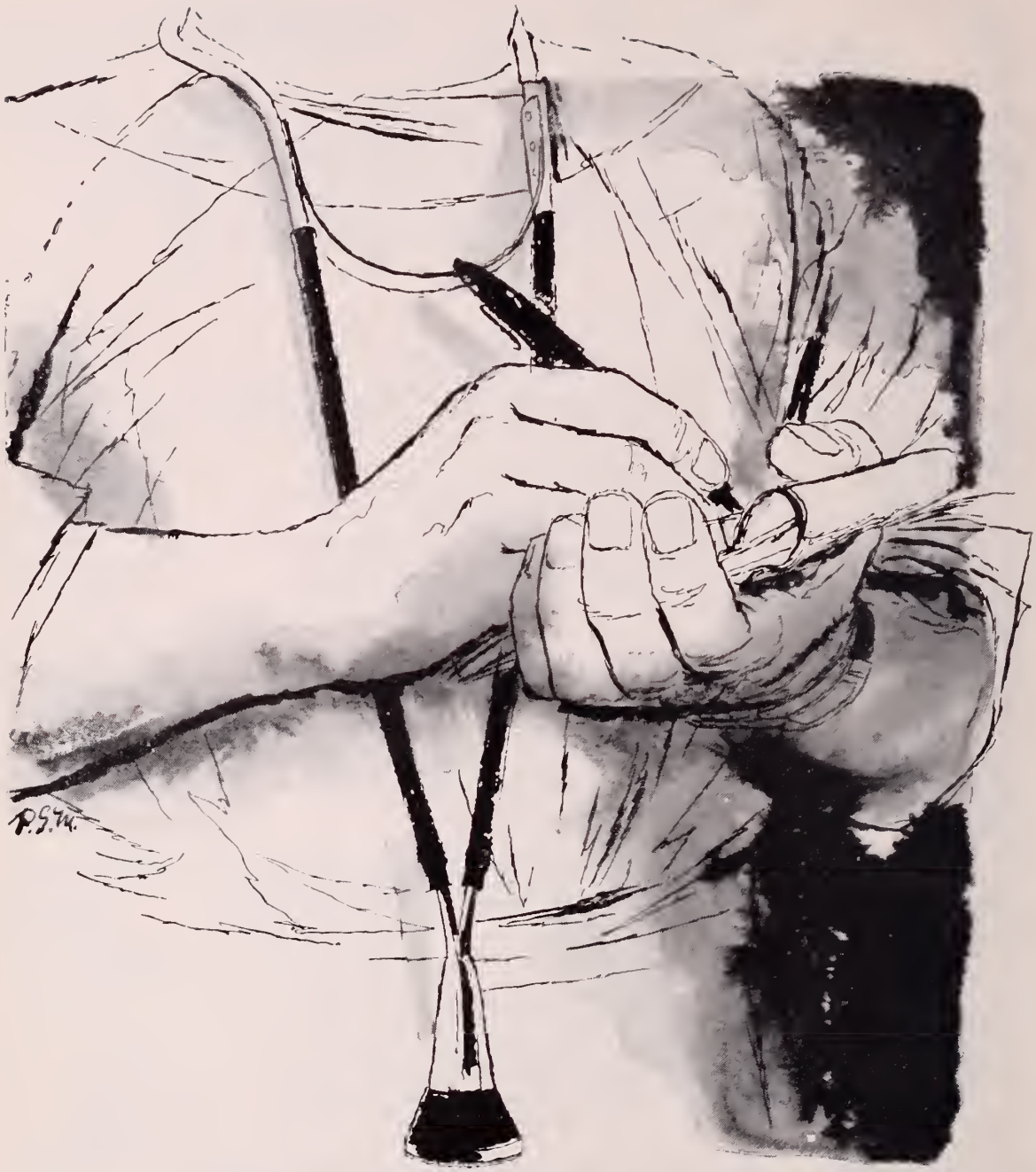
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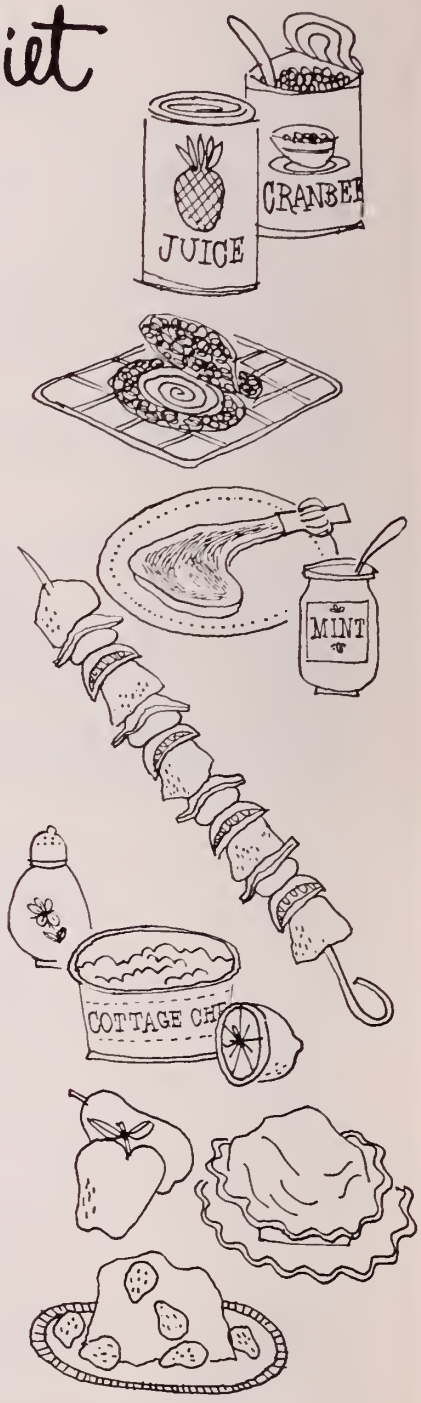
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Most vegetables can be dressed simply with lemon juice or an herb vinegar. And tomato halves come out from under the broiler bubbly with brown sugar and sweet basil on top.

On green salads, cottage cheese thinned with lemon juice, sparked with paprika, makes the dressing. And on fruits, try lemon juice, honey and chopped mint.

For dessert, angel cake or meringue shells go nicely under fruits—skim milk powder makes the "whipped cream." Snow pudding is a simple dessert—fresh fruit, even more so. And for a change, your patient may like his fruit baked in grape or cranberry juice.

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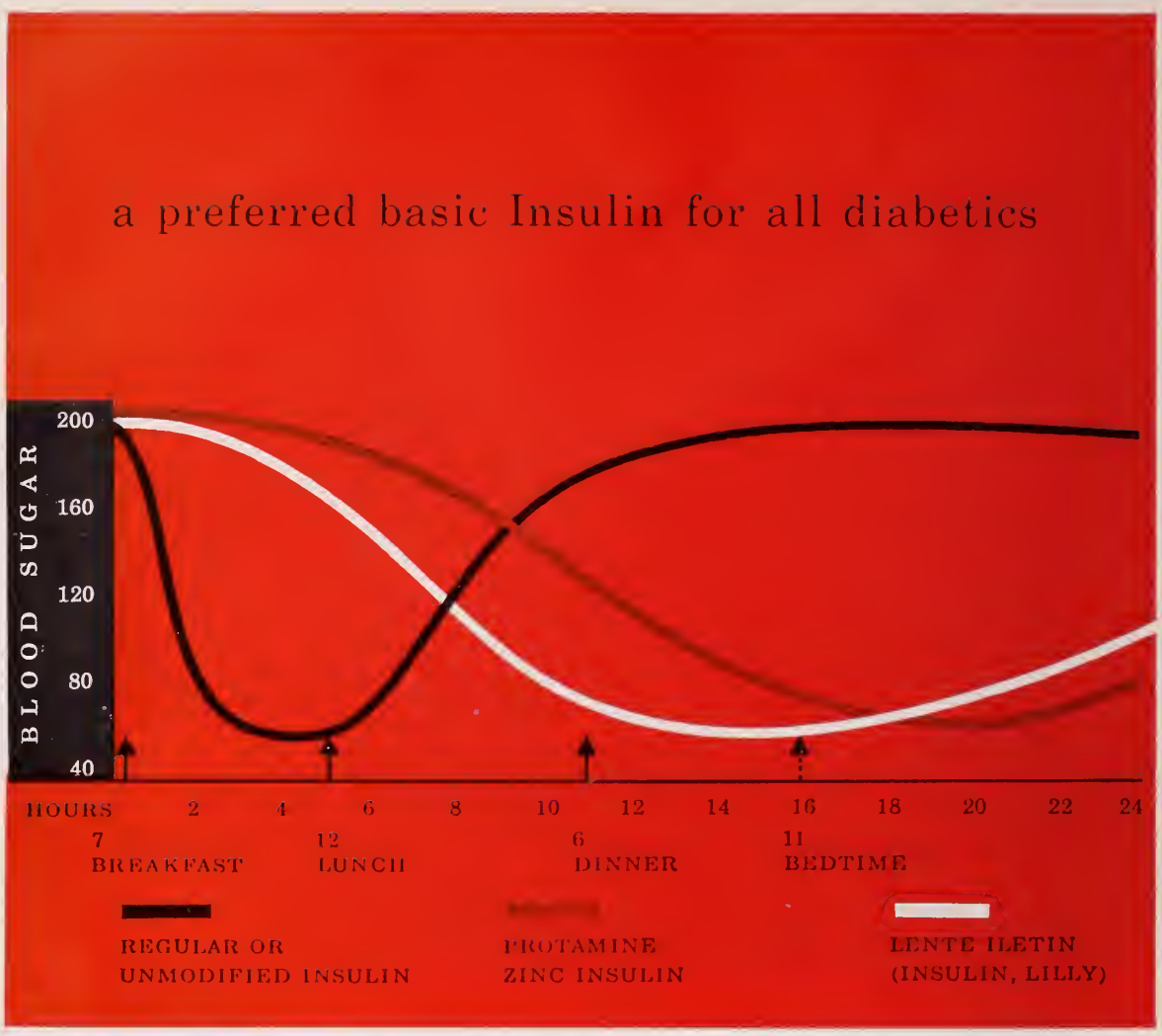
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XLII | Jacksonville, Florida, July, 1955 | No. 1

Gallbladder and Bile Duct Disease

Claude J. Hunt, M.D.
Kansas City, Mo.

I appreciate the honor you have conferred upon me by asking me to appear upon your program. My remarks are related to my personal conception of the gallbladder problem and the approach I believe is adequate for its management.

There are few benign conditions that present more potentialities for serious complications than gallbladder disease and few surgical problems that require more technical skill and more accurate identification of anatomic structures than the operation of cholecystectomy. One false move may result in a fatality or may inflict a ductal injury which will require a further surgical attempt to correct, often unsuccessful.

Delay in surgery for gallbladder disease, especially stones, may present complications of a serious hepatic nature, from which the patient may never fully recover, although successfully operated upon. It, therefore, is essential that gallstones, when detected, should be removed. It is only by early surgical approach that the complications of ductal obstruction, hepatitis, cholangitis, acute gallbladder infection, pancreatitis and cancer of the gallbladder can be reduced to a minimum. With the procedure of cholecystectomy in the uncomplicated calculous gallbladder, the technical difficulties are materially lessened and fewer surgical tragedies will occur.

Radiographic Aids in Diagnosis

Facilities are available for the accurate diagnosis of suspected gallbladder disease. Perfection in the technic of visualization of the gallbladder, by the use of an opaque medium, has resulted in the detection of obscure pathologic conditions and in stone identification. A gallbladder that is not visualized under favorable conditions by cholecystography can be considered a pathologic one. For cholecystography to be effective, one must be certain that the patient takes the medication, does not vomit it and has no diarrhea.

A gallbladder may not be visualized when there is associated pathologic change in the upper right quadrant of the abdomen or a functional disorder. Lahey and Jordan[1] reported instances of nonvisualized gallbladders that later were visualized after medical management for irritable or spastic colons. Lockwood[2] by personal communication reported 46 nonvisualized gallbladders out of 21,104 visualizations, that at a later date showed normal visualization. Eleven were associated with the so-called irritable bowel. This is a small number, but associated conditions must be considered in evaluating cholecytographic findings.

Cholecystography does not visualize the extrahepatic bile ducts, and the need for an opaque medium that will visualize these ducts has long been evident.

Oral cholangiography by Telepaque, as reported by Twiss, Beranbaum, Gillette and Poppel,[3] visualized the bile ducts in 85 per cent of the postcholecystectomy patients.

Recently, a contrast medium has been developed which, when given intravenously, opacifies the extrahepatic bile ducts. This has been described in a preliminary report by Berk, Karnofsky, Shay and Stauffer.[4] The concentration in the bile, by which it is excreted, is greater than in the blood. Only a small amount is excreted by the kidneys. They report that the common duct could be detected in most cases and both hepatic ducts and biliary ducts were frequently seen.

Glenn, Evans, Hill and McClenahan[5] reported upon the use of Cholografin in the visualization of the extrahepatic bile ducts in the cholecystectomized patient. They reported a delineation of these ducts in 75 per cent of instances after cholecystectomy and in over 90 per cent of patients who were free of jaundice and hepatic damage.

Read before the Florida Medical Association, Eighty-First Annual Meeting, St. Petersburg, April 5, 1955.

It is a nonoperative method for evaluating the extrahepatic biliary ducts in the patient with the postcholecystectomy syndrome.

In a personal communication Dr. Frank Glenn[5] stated: "We have examined 121 patients who have had persistent, or the reappearance of, symptoms after cholecystectomy. The common duct was satisfactorily visualized in 105 or 86.8%. The most frequent evidence of nonvisualization was jaundice and impaired liver function. Abnormalities of the biliary ductal system were demonstrated in 40 patients including: cystic duct remnant, 18; calculi, 11; adhesive bands and strictures, 11. In 20 patients the only abnormality demonstrated was a dilatation of all or a portion of the ductal system to 7 millimeters in diameter or more. We believe this is significant. Fifteen of the 121 patients had no abnormality of the ductal system. In a solitary, obese individual without signs of jaundice and with normal liver function, the common duct was not visualized. Twenty-six of these 121 patients were found by additional examinations to have duodenal ulcer, hiatus hernia, pancreatitis or renal disease that might wholly or in part explain their symptoms."

In ductal obstruction visualization may not be successful as too much of the dye will pass through the kidneys. Cholografin must be used cautiously as severe reactions may result. Sensitization tests should precede the intravenous use of this drug. It is not frequently used in this country and by inquiry among radiologists, I have found little enthusiasm for it, based largely upon the fear of reactions.

Liver Function Tests

Liver function tests have aided materially in the differential diagnosis between ductal obstruction and hepatic jaundice. The clinical evaluation of the patient, relating to history, onset of jaundice and physical examination cannot be disregarded. A deep jaundice and an enlarged palpable gallbladder with acholic stools and no urobilinogen in them are indicative of cancer of the head of the pancreas. A jaundice of less intensity and a nonpalpable gallbladder suggest a calculous ductal obstruction and a contracted fibrotic gallbladder.

The icteric index is the base line for the estimation of the degree and progress of jaundice.

The alkaline phosphatase is elevated in 88 per cent of cases of cancer obstruction.

When there is a speedy response of the prolonged prothrombin time by vitamin K therapy and there is an associated normal serum protein and a balanced albumin-globulin ratio, a favorable evaluation can be made as to the patient's ability to withstand surgery.[6]

A prolonged prothrombin time that does not respond to vitamin K therapy is indicative of severe cellular damage of the liver.

Zollinger and Seleeby[7] stated that the cephalin flocculation is elevated in 80 per cent of the cases of medical jaundice. The thymol turbidity is not so accurate, being elevated in 40 per cent of the cases of medical jaundice and in 33 per cent of the cases of obstructive jaundice.

Jaundice of over one month's duration will produce secondary liver damage; so the value of liver tests must be evaluated accordingly. Pancreatitis is frequently associated with gallbladder disease, and the blood amylase is elevated early in most acute infections of the gallbladder.

Often before obstruction occurs, the early symptoms are so mild that the distress, flatulency and dyspepsia are attributed to indiscretions of diet, overweight, or advancing years. Little attention is paid to them until biliary colic, acute infection, or jaundice appears. Liver function tests here are of little value. Cholecytographic studies, however, will produce much information of diagnostic value.

Effects of Ductal Obstruction

Blockage to the flow of fluid of any tubular organ will result in back pressure, tubular dilatation and distortion of the architecture of the structure. Ductal sacculation, stenosis of segmental sections, rupture of ducts and pressure atrophy of surrounding parenchyma will eventually follow. This is notably so in urinary obstruction, which results in a progressive hydronephrosis and severe renal damage.

The architecture of the biliary tree is similarly affected. Obstruction to the flow of bile by stone or imflammation results in dilatation of all the bile ducts proximal to the site of the obstructing agent. The peripheral ducts and intercellular canaliculi of the biliary tree eventually become dilated and sacculated; the terminal ducts often rupture and become clubbed. The expanding ducts produce pressure upon the surrounding parenchyma with degeneration and atrophy of the liver. It is in reality a hydrohepatosis. This process of the effect of bile duct obstruction has been well described by Sanders.[8]

Stasis of this nature, with desquamation of epithelium and accumulation of debris, may result in stone formation, which later may produce

ductal obstruction after surgery. Inadequate drainage and infection from this persistent intrahepatic pathologic condition may result in recurrent attacks of cholangitis..

A functionless gallbladder, resulting from chronic cholecystitis, produces a similar but less rapid change. Prolonged infection and hepatic degeneration seriously lower the patient's resistance to surgery, present technical difficulties, increase the incidence of postoperative complications, prolong convalescence and may affect the future health and well-being of the patient. One need only to operate upon a patient with deep jaundice, presenting a small contracted fibrotic gallbladder and a thick-walled dilated common duct, containing mushy granular material, to be convinced of the serious error in judgment in advising delayed surgery in gallbladder disease.

The Noncalculous Gallbladder

As one extends his experience in gallbladder surgery, the less he is inclined to remove the noncalculous gallbladder or the gallbladder that is visualized but shows slow and retarded emptying. The results are disappointing when such gallbladders are removed solely upon the basis of pain and distress, without cholecystographic evidence of disease or without gross evidence of pathologic change or the presence of stones on exploration. There is likely to be a recurrence of the distress, a postoperative dyskinesia. It is possible in such cases that small stones in the common duct were present and overlooked; but this is unlikely without disease of the gallbladder, or of the biliary tract, being evident at the time of operation. Before one operates with such questionable symptomatology, other organic disease, like pancreatitis, ulcer of the posterior wall of the duodenum or functional conditions relating to pylorospasm, irritable colon or ampullary dyskinesia, should be carefully considered.

Like Allen,[9] I think little of the necessity of a microscopic slide to make a diagnosis of cholecystitis. Even when gross cholesterosis is present, cholecystectomy frequently has failed to relieve the patient of symptoms.

Value of Abdominal Exploration

When operation is performed for any nonacute condition of the gallbladder, systematic exploration of the abdomen should be made. Associated disease often will be revealed. Recently I detected an unknown gastric ulcer and performed an associated subtotal gastric resection. On two occasions by this systematic abdominal examination I have discovered an annular carcinoma of the transverse colon and have resected the lesion simultaneously with cholecystectomy.

An ulcer of the posterior wall of the duodenum is encountered occasionally in gallbladder surgery. It may have been the major cause of the distress, which was overlooked upon finding a nonfunctioning gallbladder by cholecystography. It is accessible for easy detection during the operation.

Acute Cholecystitis

The acutely diseased gallbladder can be approached from two angles: the view of those who would remove all acutely inflamed gallbladders and that of those who would delay operation with the hope that the acute process will subside and the operation can be performed later at a more appropriate time, as Doubilet, Reed and Mulholland[9,10] observed. The condition, I think, is comparable to the bleeding duodenal or gastric ulcer. I would never think of immediate operation upon all bleeding ulcers. I would always attempt to re-establish circulatory balance and reserve operation for that small group in which the bleeding did not show signs of abating after a preliminary trial of medical treatment. Then I would fortify the patient by multiple transfusions of sufficient number to restore circulatory balance and resect the ulcer immediately. Likewise, with the acutely diseased gallbladder, I know that in many instances the condition will subside under medical management and the operative procedure can be accomplished more successfully at a more favorable time. The point is which ones will subside without perforation.

The process is related to cystic duct obstruction by stone, to vascular occlusion by the associated edema, inflammation and induration, and occasionally to a chemical reaction from pancreatic enzymes or a concentration of bile salts in the gallbladder.

If the pain is sustained and the mass remains and increases in tenderness, with muscular spasm, and the systemic response of a rising temperature and an elevated white blood cell count is present, the process may be assumed to be progressing and demand immediate operation.

Pain and tenderness are the most important indications for operation. It is usually safe to observe the progress of the reaction for one or two days. It is never an emergency similar to a perforated peptic ulcer or an acute appendicitis. If the acute process has not regressed in 48 to

72 hours, operation should be performed at once.

When the acutely inflamed gallbladder ruptures, it will usually be either into the liver or into the surrounding peritoneal structures, forming a localized hepatic abscess or a pericholecystic abscess. It rarely ruptures into the free peritoneal cavity as it is walled off by the duodenum, transverse colon, hepatic flexure of the colon and the liver itself. In acute cholecystitis I have observed an incidence of about 10 to 12 per cent leakage or perforation. This I did not believe until I was asked by Dr. R. L. Sanders[11] years ago to discuss his paper on "Perforation of the Gallbladder" before the Western Surgical Association. I had always thought that perforation meant perforation into the free abdominal cavity. I found upon looking up my records that many perforated into the liver, many resulted in a pericholecystic abscess, and a few perforated into the duodenum or colon. I reviewed chart after chart and I was astonished at the frequency of the complication.

I have seen many gallbladders that were gangrenous or had gangrenous areas, with recovery of the patient without complications following cholecystectomy. Most of the perforations produced no more serious complications than a pericholecystic abscess, or a large necrotic area in the gallbladder bed. In such cases recovery followed with adequate drainage of the abscess. In only 1 case a subphrenic abscess developed, which was successfully drained.

Of 5 patients 78 to 84 years of age subjected to cholecystostomy for acute cholecystitis, 2 subsequently had to have a cholecystectomy.

I have had 5 cases of perforation into a viscus that required operation because of intestinal obstruction. In 3, there was erosion through into the duodenum, producing obstruction in the lower part of the ileum, with relief by operation; in the remaining 2 there was perforation into the colon, with subsequent extraction of an obstructing stone from the rectum.

Cholecystic duodenal fistulas are frequently not recognized until a gallstone is found to be the factor in obstruction of the small intestine. They usually give few symptoms as the gallbladder has emptied itself of stones into the duodenum by the formation of a nonsurgical cholecystoduodenostomy. I have encountered them in operations for other conditions and have made no attempt to release them. Later surgery has not been required. A good stoma permits good drainage and no cholangitis. It is only when the stoma is small and the gallbladder cannot drain itself of residual stones that symptoms persist and surgery is required.

These sequelae of gallbladder disease that have a bearing upon ductal obstruction and acute disease of the gallbladder are common occurrences in the experience of anyone who does a large volume of gallbladder surgery. They can all be prevented by early cholecystectomy before the so-called innocent stones have started upon their path of devastation.

The indications for drainage or removal of the acutely inflamed gallbladder must depend upon good surgical judgment. It is better to remove the gallbladder if feasible. The operation is facilitated by the edema which aids in finding the line of cleavage and in separation from the liver bed. There are only a few instances in which removal will be contraindicated. They are related to age, a cardiac condition, systemic disease, and unfavorable local anatomic complications. If in doubt, do only drainage. No one can be criticized for a conservative measure in such an acute situation. It is better to have a well patient and a second operation than to have a gallbladder out and a damaged bile duct. In years gone by, I have advocated this procedure in thyroid surgery on the patient with severe hyperthyroidism. I would rather have two operations and a live patient than to take a chance on one operation and an increased mortality rate. I am sure I have saved lives by this approach.

This procedure is equally applicable to obstructive or partially obstructive lesions of the left colon. Multiple operations there are mandatory.

This principle applies to all surgical problems in which major complications may indicate a conservative procedure rather than the more desired definitive one.

Cancer of the Gallbladder

The incidence of this complication is very low, probably not more than 1 or 2 per cent in my experience, but recorded by some as 4 or 5 per cent. I have always found it associated with a calculous gallbladder. In no case has cure been effected by surgery. I have removed large wedges of liver in continuity with the gallbladder; this measure adds little to the postoperative extension of life. The liver is spongy, and although all visible cancer is removed, it soon recurs. Right hepatectomy has been performed without cure. It is a formidable operation, accompanied by excessive mortality, and will not be accepted as

a standard procedure for cancer of the gallbladder.

The incidence of cancer of the gallbladder is higher than the mortality from gallbladder surgery, and cholecystectomy for stones is an excellent prophylactic measure against the development of cancer.

Heart Disease and Gallbladder Disease

In many patients chronic gallbladder disease or ductal obstruction is associated with chronic myocardial or valvular heart disease, or becomes a problem in a patient who had previously been the victim of a coronary occlusion. These patients withstand surgery remarkably well and apparently have a greater heart reserve after they have been relieved of pain, gas and indigestion. I have removed some infected gallbladders associated with advanced heart disease with surprisingly good results upon the heart. Many functional disorders are relieved entirely. The relationship has been mentioned for years, and favorable results have been experienced and reported by others.

Diabetes and Gallbladder Disease

In the presence of acute infections of the gallbladder, diabetes is aggravated. The demand for insulin is increased, and carbohydrate tolerance is lowered. As in hyperthyroidism, insulin requirements are reduced and carbohydrate tolerance is increased after cholecystectomy.

Exploration of Common Duct in Obstructions

Ductal obstruction is a surgical problem and may well be mentioned here because of its importance in the management of gallbladder disease. Exploration of the common bile duct adds little to the seriousness of the operation, and in my experience has contributed nothing to increasing morbidity and mortality.

It requires good exposure, accurate dissection of the ducts and gentleness during the exploration. I am sure the duct should be explored more frequently. The obstruction is usually caused by a stone, and certain indications should guide one in making the decision to explore the duct:

1. A palpable stone in the duct
2. Dilatation of the duct
3. Jaundice or the history of jaundice
4. Small stones in the gallbladder with a patent cystic duct
5. Murky flocculent bile found by aspiration of the duct
6. Small gallbladder with stones and an enlarged common duct.

The stones can be extracted by scoop and the ampulla dilated in almost all instances. The scoop should pass freely into the duodenum, and the ducts should be flushed with water. A T-tube should be used and brought out through a stab wound; in all cases of removal of the gallbladder the wound should be drained in a similar manner. Postoperative cholangiography should be carried out before the tube is removed.

Occasionally it is wise to resort to visualization of the duct on the operating table. This is to be commended. Many use it routinely. I believe that the duct can be explored at operation and that operative cholangiography is rarely necessary. I explore the common duct in over one third of my cases and find stones in three fourths of them. Never explore a small common duct; stricture may result.

Choledochoduodenostomy

Choledochoduodenostomy is an operation of great merit for ductal obstruction at the ampulla which cannot be dilated. It is effective in fibrosis from pancreatitis, ampullary stenosis and sometimes carcinoma of the head of the pancreas. A wide stoma will not produce reflux of duodenal contents into the hepatic ducts or cholangitis. It will drain well. Water seeks its level; so does bile. Cholangitis comes from stenosis, obstruction and back pressure. The merits of this procedure have been discussed and advocated in selected cases by Sanders.[8] I have used it frequently and found it effective.

Biliary Dyskinesia

The postcholecystectomy syndrome may be the result of spasm of the sphincter of Oddi or of overlooked stones, pancreatitis or duodenal ulcer. Biligrafin may be valuable in detecting overlooked stones or ductal obstruction; however, there is an error of 15 to 20 per cent in which visualization is indefinite or not present. In any event, if the symptoms persist, I believe the common duct should be explored surgically.

The common duct should be opened and carefully investigated for stones. A 4 mm. scoop should be passed into the duodenum and the duct carefully palpated over it. If one is in doubt, the duodenum should be opened and the ampulla inspected. If the ampulla is small, the anterior portion of the sphincter of Oddi can be incised. The mucosa of the duodenum and the common duct should be sutured. Suturing prevents hemorrhage and stenosis and keeps the sphincter open.

Obstruction in Head of Pancreas

Lesions causing obstruction in the head of the pancreas are usually malignant and are suggested clinically by an enlarged palpable gallbladder, painless progressive jaundice and acholic stools without urobilinogen. Widening of the curve of the duodenum is radiologically suggestive.

Radical resection of the head of the pancreas has not proved more serviceable than conservative operations. The mortality is high, and in about one fifth of the cases the lesions prove to be benign. Biopsy is uncertain and dangerous because of pancreatic leakage. Recently I lost a patient because of a pancreatic biopsy which proved nothing. A conservative operation was performed, fat digestion followed, and death ensued. Autopsy revealed a cancer of the pancreas.

Radical operation should be performed for cancer of the ampulla of Vater. In my experience with this operation the longest period of survival was four years and eight months, with death due to another cause. Autopsy was not obtained.

Summary

Early operation in gallbladder disease is urged.

Complications result in hazards and uncertain results.

Cholecystography and cholangiography are discussed.

Means for early diagnosis of gallbladder disease are available.

Visualizing processes are becoming clinically applicable for delineation of the biliary tract.

Liver functional tests for differential diagnosis between hepatitis and ductal obstruction are discussed. The importance of the clinical history and physical examination must be correlated with any laboratory data.

The effects of ductal obstruction upon the intrahepatic bile ducts and liver are extensive and persistent. They are described.

The acutely diseased gallbladder and indications for immediate or delayed surgery are discussed. The local condition relating to drainage or removal is mentioned as a guide in making a decision.

The relation of gallbladder disease to heart disease, to diabetes and to malignant disease is discussed in some detail.

Opinions concerning surgery of the common bile duct are presented, and the value of anastomosis of the duct to the duodenum is presented.

The indications for sphincterotomy are mentioned.

Palliative surgery is recommended for cancer of the head of the pancreas.

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1612 Professional Building.

The Ninth Annual Clinical Session of the American Medical Association is being held at Boston, November 29-December 2, 1955.

What Is Your AMA?

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In my travels around the country, I have found that many of my friends in medicine know little about the workings of their national organization — the American Medical Association. They are not aware of the fact that their local and county medical societies play a vital role in determining the policies of the A.M.A.

The A.M.A. is a federation of state medical associations which are represented in the House of Delegates by one delegate for every 1,000 dues-paying members. Similarly, the state associations are federations of county medical societies which are represented in the state House of Delegates on a proportionate basis.

Policies of the A.M.A. originate at the grass-roots level — in the county societies. The national organization does not dictate orders from the top down; the orders come from the bottom up. A local society determines by majority vote whether to refer an action to the state level. At the state meeting, the action is presented before the House, which sends it to an appropriate reference committee, and then acts on the recommendation of the committee — again by simple majority vote.

If it is decided to send the resolution to the A.M.A. House of Delegates, the proposal gets similar treatment. It is referred to a committee for hearings and sent back to the House with a recommendation for final action. The reference committee hearings are open to every physician in the United States. Any doctor who is present at the A.M.A. meeting can step into a reference committee session and have his say on whatever proposal is being discussed.

We have many committees and councils at the A.M.A. to carry out the programs which are set up through this democratic procedure. Among these groups is one which serves as a sort of Supreme Court for American medicine—the A.M.A.'s Judicial Council. Let me give you an example of what I mean.

Some time ago a New York doctor was expelled from his county medical society on the grounds that he engaged in unethical advertising. He appealed the action to the state association, which upheld the decision of the local group. The physician then carried his appeal to the A.M.A.'s Judicial Council. After holding a number of hearings, and considerable deliberation, the Council found that the doctor did not personally engage in advertising.

Now the right to this appeal is open to every physician, and issues which cannot be resolved at the local and state levels can be brought before the Judicial Council.

A.M.A. Activities

Most of the activities at the A.M.A. are directed at providing increasingly better medical care for all of the people in our country. We have an annual budget of about $9,000,000, and the bulk of it goes for activities such as the physician placement service of the Council on Medical Service. Through this section of the Council, which works closely with the state medical associations, we encourage young physicians to establish their practices in rural communities.

Another function of the Council on Medical Service is to aid in the development of voluntary health insurance programs for the benefit of the people. The Blue Shield programs which we established are a major weapon against socialized medicine. I should like to see some sort of arrangement made in the Blue Shield contracts whereby other medical men besides surgeons — such as I am — would get some benefit.

Through our Council on Medical Education and Hospitals we try to maintain a high quality of medical education and hospital care. Some people have the notion that we dictate to the medical schools as to the number of students they may carry and who should be admitted. This is a completely false notion. We hope that the schools will carry only as many students as they can adequately train with the facilities they have. As for saying who should be admitted, let me tell you of

President-elect of the American Medical Association.
Read before the Florida Medical Association, Eighty-First Annual Meeting, St. Petersburg, April 4, 1955.

a personal experience. During the past year, I have been asked to help 22 boys get into medical school. Only four of these were accepted. I would hardly call that an example of great influence.

We have our Council on Mental Health, which is run by some of the greatest psychiatric brains in the country. This group is vigorously engaged in seeking to correct a situation in our mental hospitals which I have described in previous talks as being a national disgrace.

Many of our mental hospitals are only storage plants, where men and women are set aside indefinitely with little hope for cure. With more than half the hospital beds occupied by persons suffering from mental disturbances, we cannot stall around in providing adequate rehabilitation care.

You cannot cure mentally sick people with buildings, and many of our psychiatrists deplore the concept of a mental hospital as the primary tool for treating these unfortunate people. The cost of building and maintaining these storage plants is tremendous, and they accomplish little because they are overcrowded and understaffed.

I understand that here in Florida you are doing something constructive about this problem and that you have recently established a committee on mental health. This is good; we need more active interest of this type to aid the mentally ill.

The states now spend $560,000,000 each year on the care of the mentally ill, and the federal government spends $548,000,000. A billion dollars a year is lost by these people in wages, and the country loses $3,000,000,000 in productivity. Yet we spend a measly $6,500,000 a year in research on mental illness.

Many dramatic developments in the treatment of the mentally ill have come about in recent years. For example, scientists of the National Mental Health Institute have devised technics which permit the measurement and analysis of blood flowing through the living, thinking brain.

We can lick mental illness the same as we did smallpox, typhoid, yellow fever, malaria and other diseases which were once thought incurable. But we need intensive studies to determine the proper place of latest treatment technics in the mental health picture. For this reason the A.M.A. is supporting two administration bills before the Congress.

One of these measures authorizes a five year program of grants to states for mental health services and special projects for the development of improved methods of care, treatment and rehabilitation. The other is a resolution authorizing the federal government to finance an intensive three year survey of all aspects of the mental health problem. The study would be conducted by private, nongovernmental associations, such as the Joint Commission on Mental Illness and Health which has recently been formed by the A.M.A.'s Council on Mental Health and the American Psychiatric Association's joint executive committee.

The Joint Commission, which will also sponsor a national conference on mental health every two years, has the same objectives as are embodied in the mental health bills now before the Congress. We want to make a national survey of all aspects of the problem and to formulate a program for improvement in diagnosis, treatment and care of the mentally ill and retarded.

Medical Ethics

Now, a word about medical ethics before I close. In my book, medical ethics involves just one principle — doctors take care of sick folks — period. All the rest of it is just rules of conduct for physicians in their dealings with each other. Recently the A.M.A. revised its Principles of Medical Ethics. I cannot understand how anyone can revise a fundamental principle. I like to think that what we revised were the rules that guide us in the practice of our profession.

It is my firm belief that most doctors are good men. They practice good medicine and they take good care of their patients. I think that doctors have every right to be proud of their profession and they should not be ashamed to express their faith in a Supreme Being.

I am not ashamed of my faith in God, and I believe I am a better doctor for it. No physician walks alone into a sick room. He can do only so much with the material tools of scientific medicine and must leave the rest to a Superior Being. I do not ask you to become creedists; I only ask you to join me in a firm belief in the Fatherhood of God and the Brotherhood of Man.

501 Commerce Building.

Surgery of the Heart and Great Vessels

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MIAMI

Great and almost inconceivable strides have been made in recent years in the field of cardiac surgery. A mere 15 years ago practically no surgical correction of the crippled heart could be accomplished. Through the bold and untiring efforts of Cutler, Gross, Craaford, Beck, Blalock, Brock, Bailey, Swan and other pioneers, a vast new field has been developed. Most of the basic work and technical experience has been developed in the experimental laboratory and then applied to human patients. Expertly induced anesthesia, hypothermia, extracorporeal and controlled cross circulation will further expand and increase the safety of surgery of the heart and great vessels.

The most commonly encountered congenital and acquired cardiac defects for which surgery offers some relief will be discussed. In addition, the experimental phases of this field will be mentioned. Opinions expressed are based upon current literature plus the experience gained from treating 129 cases.

Correctable or Partially Correctable Cardiac Defects

Congenital

Patent Ductus Arteriosus. — Patent ductus arteriosus was purely a medical disease until 1938 when Gross first corrected it by ligation. This procedure met with success and is the one development which opened up the whole field of cardiac surgery. This arteriovenous shunt may carry up to 80 per cent of the left ventricular output into the pulmonary artery. One or more of the following may occur: (1) left ventricular hypertrophy, (2) subacute bacterial endarteritis, (3) pulmonary vascular sclerosis, (4) pulmonary hypertension and (5) cardiac failure.

The consensus is that patent ductus arteriosus should be corrected in almost all patients past 5 years of age. The one exception would be the elderly person without complications. If the patency persists at the end of the fourth year, the ductus seldom closes spontaneously and thus reduces the life expectancy by nearly one half. Diagnosis depends upon the continuous "machinery" murmur in the left second interspace and the fluoroscopic findings of a prominent pulmonary artery segment with strong pulsation and increased vascularity of the lung fields. The left ventricle and left atrium are often enlarged (fig. 1).



Fig. 1. — Mrs. F. O. Preoperative chest roentgenogram of a 24 year old woman with patent ductus arteriosus showing enlargement of the left ventricle, increased pulmonary vascularity and congestion.

Two operative procedures have been used successfully to correct this abnormality: multiple ligation of the ductus, and division plus suturing of the ductus. Since the latter procedure carries a slightly greater surgical risk, multiple ligation appears to be the procedure of choice in the routine case. Blalock (1951) stated that in only 1 of 300 cases in which he performed multiple ligations was there reopening. I use this procedure routinely. In my cases the patients have ranged in age from 3 to 24 years. They have withstood

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surgery well and all have been rendered asymptomatic and have resumed unrestricted activity. In one 24 year old woman who had experienced one or more bouts of congestive heart failure prior to surgery and in whom a short, unusually large ductus was encountered, there is auscultatory evidence that the ductus has partially reopened. There has, however, been no recurrence of the congestive heart failure. This case occurred early in this series, and the reopening of the ductus is probably due to the fact that I did not adequately close it by the multiple ligatures.

COARCTATION OF THE AORTA. — This lesion is a partial or complete stenosis of the aorta usually just distal to the origin of the subclavian artery and approximately at the junction of the ductus with the aorta. The constricted area may be localized or diffuse. Aortography and angiocardiography are diagnostic aides in determining the location and extent of the lesion preoperatively. Symptoms may be minimal, but usually headaches, cold feet and legs, syncope, increased fatigability, epistaxis and decreased exercise tolerance are present.

Coarctation is usually accompanied by hypertension in the upper portions of the body, hypotension in the lower portion of the body and notching of the ribs after age 12, and often is complicated by left ventricular hypertrophy and the other sequelae of hypertension and atherosclerosis.

Craaford of Sweden and Gross of Boston independently and almost simultaneously in 1944 accomplished a satisfactory correction of this serious defect. Apparently Craaford's work was slightly earlier than that of Gross. If possible, the procedure of choice is to resect the stenotic area and approximate the ends of the aorta by suture. When the defect is too extensive for this approach, either the left subclavian artery may be severed and sutured to the distal segment of the aorta or a homograft may be used to bridge the defect, as outlined by Gross. Careful detail as to collections, preparation and storage of grafts must be observed. The over-all operative mortality rate ranges between 10 and 20 per cent depending upon the age of the patient and the type of defect encountered.

Optimally, surgical correction should be carried out when body growth is near completion and before the onset of complications which increase the surgical risk or impair the final result. If one takes these criteria into consideration, surgery is indicated between ages 12 and 20.

TETRALOGY OF FALLOT. — This malformation consists of four well known basic defects: (1) pulmonary stenosis, (2) dextroposition or overriding of the aorta, (3) right ventricular hypertrophy, and (4) interventricular septal defect. There is usually cyanosis, polycythemia, clubbing of the digits, underdevelopment, decreased oxygen saturation of the blood, right axis deviation, a harsh systolic murmur, and greatly reduced exercise tolerance. The physiologic disturbances are due to insufficient amounts of blood reaching the pulmonary vascular bed to pick up oxygen and the mixing of the right and left ventricular blood. These so profoundly affect the patient that he usually does not live beyond the age of 25 (fig. 2).



Fig. 2. — C. W., aged 7. Preoperative roentgenogram in a case of tetralogy of Fallot showing concavity of the left upper cardiac border and clear lung fields.

Surgical approach to this condition was first reported in 1945 by Blalock and Taussig, who utilized one of the most ingenious of all surgical procedures. They anastomosed the innominate artery's subclavian branch to the pulmonary artery, thereby shunting more of the incompletely oxygenated blood into the pulmonary vascular bed. The original procedure of Blalock did not correct any of the basic defects but created a fifth; however, it increased the blood flow to the lungs and thereby improved oxygenation of the blood. The operation of Blalock plus the modification by Potts has been performed thousands of times

with a mortality of approximately 15 per cent. In the successful cases the exercise tolerance is usually markedly improved. The optimum age is 10 to 15 years, but no patient should be denied the operation, regardless of age, if the condition is deteriorating.

Whenever the obstruction to the pulmonary blood flow is limited to the pulmonic valve itself or is infundibular in type, the Brock (1948) procedure seems preferable to the Blalock-Taussig operation. In this procedure the stenotic valve is cut by a valvulotome introduced through the wall of the right ventricle, or a portion of the infundibulum is rongeured away. This procedure has the advantage of minimizing one defect without creating another as does the Blalock-Taussig operation, and it carries a comparable operative mortality.

Pure Pulmonic Stenosis. — This lesion was once considered rare, but cardiac surgeons are seeing it with increasing frequency. The condition varies in severity from that observed in the asymptomatic patient with a small heart to that characterized by tight stenosis and cardiac failure in the severely ill patient. There is partial obstruction to the pulmonary outflow tract resulting in hypertension in the right ventricle and secondary hypertrophy of it. The pulmonary artery may be small, normal, or large in size, and the pressure within it is lower than normal. The pressure recording through the cardiac catheter may differentiate between valvular and infundibular stenosis. The poststenotic dilatation often seen in the valvular obstruction may make the picture somewhat confusing. The clarifying feature is decreased or absent pulsations of the pulmonary vascular bed. There is a loud systolic murmur and a prominent systolic thrill. In the mild or asymptomatic type one should perform serial studies rather than resort to surgery. The trend, however, is toward early operation in patients with a right ventricular pressure of over 75 mm. of mercury. The Brock procedure as proposed in this country by Potts and his co-workers, Downing and Bailey and Glover, is a satisfactory corrective procedure but is a "blind" direct attack upon the valvular or infundibular obstruction. Swan has performed a few operations of this type via the pulmonary artery, using direct vision technic after temporarily occluding the venae cavae, and with the aid of hypothermia.

Patients with this lesion do poorly under anesthesia, and one should anesthetize them without permitting any struggling or excitement. One must work fast until the valvular stenosis is corrected. The patient's condition then improves, and the right ventricle becomes reduced in size. The mortality rate in the uncomplicated cases is approximately 10 per cent. Associated atrial septal defects should not deter one from correcting the pulmonic stenosis. I have observed satisfactory clinical improvement in my 4 cases. In 2 of them the patient did poorly under anesthesia until the valve obstruction was relieved; then there was rather remarkable rapid improvement in cardiac function and decrease in size of the right ventricle.

Constricting Vascular Rings. — These are intriguing lesions and may consist of one of the following: (1) double aortic arch, (2) subclavian artery arising as the fourth branch of the aortic arch and passing behind the esophagus and in some cases with an attached left ductus, (3) right-sided aortic arch with the residuals of the left aortic arch forming a vascular ring, (4) the residuals of the right arch forming a ring by joining the normal left arch, and (5) variations of the obliterated or patent ductus arteriosus (fig. 3).



Fig. 3. — M. F., aged 7 months. Photograph of the posterior aspect of the autopsy specimen of a constricting vascular ring showing the right-sided aortic arch and descending aorta with the left subclavian artery passing posterior to and indenting the esophagus. The obliterated ductus is seen joining the subclavian artery producing a constricting vascular ring.

Symptoms are those of tracheal and esophageal obstruction usually occurring before the age of 6 months. Roentgen studies are usually characteristic, revealing a pressure defect on the esophagus and trachea. Occasionally bronchoscopy, esophagoscopy and angiocardiography may be of diagnostic value.

In my 6 cases the diagnosis has not been difficult. Usually the diagnosis can be strongly suspected by a history of increasing difficulty of feeding and associated dyspnea or cyanosis.

Gross (1945) performed the first successful operation for this condition. The procedure is simple and consists of dividing the constricting vascular ring. The operation should be performed without delay if the constriction is producing symptoms. If this rule is not adhered to, one may be forced to operate with the patient in an extremely poor condition. Early operation should result in a low mortality rate in the absence of other associated cardiovascular defects. In 5 of my 6 cases other associated cardiovascular anomalies were present.

AURICULAR SEPTAL DEFECTS. — The treatment of these defects has not been as satisfactory as that of the conditions previously discussed. This fact is apparent because there are several different technics being proposed, none of which has been completely perfected or thoroughly evaluated. The main circulatory fault in atrial septal defects is an arteriovenous shunt that results in recirculation of arterial blood through the pulmonary system. This increases pulmonary blood flow and results in a dilatation of the pulmonary artery and its branches and hypertrophy and dilatation of the right ventricle and atrium. Heart failure usually results. Sudden death is not an uncommon occurrence.

Indications for surgery are:

1. Progressive changes such as:
 (1) Pulmonary sclerosis
 (2) Excessive fatigue, dyspnea and hemoptysis.
2. Catheterization proof of a large shunt
3. Fluoroscopic evidence of pulmonary hypertension
4. Considerable cardiac enlargement

In the correction of these defects one must be sure that the pulmonary venous return is not to the right side of the heart.

The first reported closure of an atrial septal defect was by Gordon Murray in 1948. Gross, Swan, Bailey, Craaford and others have devised various technics which must be evaluated further before any of them can be accepted as satisfactory operations. The mortality rate remains high, and these procedures are still much in the experimental stage of development. On a small scale interatrial septal defects are being repaired by (1) atrioseptopexy, which is a closed method currently being used by Bailey and Kay in which a portion of the right atrial wall is sutured into the defect, the procedure being digitally controlled with the finger in the right atrium; (2) semiopen technic of Dr. Gross, in which an atrial well is used, the suturing taking place through a column of blood which rises in the atrial well; and (3) the open operative methods in which the venae cavae are occluded, hypothermia used and the suturing accomplished in a comparatively bloodless field. Several other technics are being used at the present time but not extensively. One of the rather ingenious ones is the polyvinyl plastic sponge closure of the defect. Corrective technics will be improved by one of the following, or various combinations of them: controlled cross circulation, hypothermia, and simple mechanical pumps.

ARTERIOVENOUS FISTULAE OF THE LUNG.— These lesions actually produce an arteriovenous shunt within the pulmonary vascular bed by which a portion of the unoxygenated pulmonary arterial blood reaches the pulmonary vein and thus the left side of the heart and the systemic circulation. As a result, there may be polycythemia, clubbing of the fingers, dyspnea, cyanosis, fainting and occasionally hemoptysis. Often, however, the only diagnostic clue is an unexplained polycythemia or cyanosis in the absence of a heart murmur. Brain abscesses, cerebral and peripheral emboli and fatal hemorrhage have been reported as complications of these lesions.

Careful physical examination may reveal a systolic murmur or bruit over the pulmonary lesion. Roentgenograms of the chest may demonstrate a pulmonary opacity which is connected by a strand or vascular shadow with the main hilar vascular trunks. Angiocardiography is of considerable value in diagnosis and in determining whether more than one lesion is present. Treatment consists of resection of the portion of the lung containing the fistula. The operative risk is not great, and the over-all results are good unless there are multiple fistulae. My experience is confined to 6 cases; in all there were classical findings, but in only 2 did the lesion produce symptoms. In 1 a spontaneous hemothorax de-

veloped, and in the other a fatal hemorrhage occurred in a patient in the fourth or fifth month of her first pregnancy. Current thought is that pulmonary arteriovenous fistulae should be removed even if they are asymptomatic.

Miscellaneous Group. — There are many congenital defects for which a satisfactory operation has not been devised. Many of them are under investigation at the present time. Some conditions falling into this group are transposition of the great vessels, Eisenmenger's complex, anomalous drainage of the pulmonary veins, interventricular septal defects and tricuspid atresia. The solution of some of these may be in the development of improved and simplified forms of extracorporeal circulation, hypothermia and the use of controlled cross circulation.

The anomalous drainage of pulmonary veins may be serious or minor, depending upon the amount of pulmonary venous blood returning to the right side of the heart. When only a small portion of the pulmonary blood returns to the right side of the heart, symptoms may be absent or mild. If there are no symptoms, no treatment is indicated. If there are symptoms, then the portion of the lung draining into the right side of the heart may be excised if this consists of not more than one lung. When all the venous drainage from the lungs is to the right side of the heart, it is not compatible with life unless there is an atrial septal defect. In this event, there is cyanosis. At the present time it is technically extremely difficult to anastomose pulmonary veins to the left atrium or auricular appendage. The structures themselves are especially difficult to manipulate and suture satisfactorily, and, in addition, the low pressure of the circulation at this level often results in thrombosis at the site of anastomosis. Two of my patients fall into this group; in 1 the upper lobe of the right lung, which was diseased in addition to having venous drainage to the right atrium via the azygos vein, was resected.

Acquired Defects

Injuries of the Heart and Great Vessels. —Contusion of the heart is often caused by automobile and industrial accidents. There may be associated shock with a weak, thready pulse, cardiac irregularity and electrocardiographic changes suggestive of coronary occlusion, or pericarditis. The treatment is similar to that for coronary occlusion. Treat the shock; use oxygen, bed rest and general supportive measures. Several patients with apparent cardiac contusion have been treated accordingly, and there has ben only 1 death in this group. This death occurred 30 minutes following a boat explosion in which the only visible injury was a contusion over the midsternum. The patient had a rapid, weak pulse, and cyanosis was present; an autopsy was not performed, but roentgen examination of the chest, thoracentesis and pericardiocentesis gave negative results.

Laceration or tearing of great vessels in the thorax is not uncommonly observed in the emergency room of large hospitals. If there has been much disruption of the continuity of the vessel wall, the patient may not be alive upon arrival at the hospital. Prompt attention to the actively bleeding vessel in the form of thoracic exploration and some type of repair are indicated. Upon encountering a completely severed subclavian and femoral artery, I have sutured both with restoration of function.

In 1946 a young adult male patient was seen who said he awoke one morning on a train and found his left arm hanging over the side of the pullman bed. The arm remained tender for several weeks and to a lesser extent for the two intervening years. On many occasions he had experienced some pain in the chest and hemoptysis. Roentgenograms of the chest had suggested pulmonary infarction. A venogram revealed almost complete occlusion of a 2 cm. segment of the left subclavian vein. There were a number of large collateral veins near the site of the obstruction. It seemed there was a thrombosis in the subclavian vein which was responsible for the pulmonary emboli. The vein was ligated proximal and distal to the area of thrombosis, and there has been no subsequent bout of pain or hemoptysis.

Penetrating or perforating wounds of the heart likewise are not uncommonly encountered in the emergency rooms of the larger hospitals. If a knife or other foreign body is embedded in the chest in the region of the heart, it should be removed preferably in the operating room, and at the time a thoracotomy is performed to control the possible severe hemorrhage. If stab wounds of the heart are considered extreme emergencies and the patient is taken immediately to surgery and the wound explored, there will be an over-all mortality rate ranging from 20 to 30 per cent.

Patients with stab wounds of the heart who reach the hospital alive already have a better chance of survival since the wound is usually small, else death would have occurred. Various authors, therefore, have investigated the nonoperative management of cases of this type. The chief danger is cardiac tamponade, which is recognized by the following signs: diminished valve sounds; increased venous pressure; decreased arterial and pulse pressure; paradoxic pulse and decreased excursion of the heart borders fluoroscopically with an increased cardiac shadow. In 1943 Blalock and Ravitch emphasized the importance of pericardial aspiration in the nonoperative management of patients with cardiac tamponade. They reported 20 cases successfully treated in such a manner with only a single fatality, which was due to laceration of a coronary artery resulting in myocardial infarction. At autopsy the pericardium was free of blood. Elkin and Campbell treated 17 patients with cardiac wounds conservatively by the aspiration technic and reported a mortality rate of 5.9 per cent.

In my experience with 17 stab wounds of the heart, all of the patients survived. The first patient was seen 24 hours after sustaining a stab wound of the heart. She presented a picture of acute cardiac tamponade. She was operated upon immediately, and large clots were evacuated from the pericardium, but there was no free bleeding from the laceration of the right ventricle. The second patient was a fisherman who had been stabbed at sea by his fishing partner. He arrived in the hopsital with acute cardiac tamponade, but refused operation. After aspiration of only 40 cc. of blood from the pericardium, his condition greatly improved, and he made an uneventful recovery. These 2 cases convinced me that conservative treatment should be given further trial. Subsequently 15 patients have been treated by pericardial aspiration without a death. One patient was subsequently operated upon three weeks after injury because of signs of chronic tamponade and sepsis. There were large clots in the pericardium, and the condition was corrected by evacuation of the clots. It appears that the vast majority of persons with stab wounds of the heart, reaching the emergency room alive, can be treated satisfactorily in a conservative manner with a much lower mortality rate than if they are all immediately taken to surgery. The surgical team and operating room should be kept in readiness so that surgery may be performed without delay if conservative therapy is not effective.

CONSTRICTIVE PERICARDITIS. — This condition is usually due to secondary tuberculous involvement of the pericardium. Many times it cannot be proved, but the evidence is preponderantly in that direction in the majority of cases. Typically, there are present progressive fibrosis and calcification of the pericardium with obliteration of the pericardial cavity and constriction of one or more of the cardiac chambers. With the passage of time atrophic changes also may occur in the myocardium. Physiologically, they result in decreased diastolic filling of the heart chambers due to the nondistensible pericardium, decreased cardiac output and increased systemic venous pressure with resulting chronic, passive congestion of the liver and ascites. From the outset exercise tolerance is poor, and in time intractable cardiac failure may occur. The correction of this condition is by pericardiectomy (fig. 4).



Fig. 4. — W. M., aged 27. Preoperative photograph of constrictive pericarditis revealing ascites and the liver extending to the umbilicus. Gynecomastica also is present.

According to Scannell, Myers and Friedlick, pulmonary hypertension is also a constant feature. They believe that adequate pericardiectomy must include complete freeing of the left ventricle. By so doing the pulmonary hypertension is relieved. Their opinion is that elevation of the peripheral venous pressure is due to involvement of the right ventricle and adequate removal of the constricting pericardium from over it, without liberation of the right atrium and great veins, relieves the peripheral venous hypertension.

I have used the left anterolateral approach with successful results. The long term results are most satisfactory if the operation is performed before serious irreversible changes have occurred.

Rheumatic Valvular Disease. — Pure mitral stenosis with or without other associated valve defect is a common complication of rheumatic heart disease. As the mitral valve leaflets fuse at the commissures, the valve opening may be insufficient to transmit the blood from the left atrium to the left ventricle. The left atrium becomes distended, and secondary pulmonary hypertension develops. This, in turn, throws an increased load upon the right ventricle, which itself hypertrophies and dilates. Decreased tolerance for exercise, dyspnea, a rapid pulse, fibrillation, pulmonary edema and hemoptysis develop. The majority of patients with a tight mitral stenosis do not live beyond middle age. As a rule, after pulmonary edema their survival time is not more than five years. Those who experience fibrillation are candidates for cerebral or other embolization. Early in the century several unsuccessful attempts by Cutler and others were made to relieve valvular stenosis. It was not until the pioneering work of Bailey and Glover that a satisfactory operation was devised. This operation consists of separating the commissures by means of the finger or a knife so as to increase the flow of blood from the left atrium into the left ventricle without producing valvular insufficiency. Great care must be taken to preserve the valve leaflets. Many surgeons have reported fairly large series of cases in which they have performed mitral commissurotomy or valvulotomy with a 5 per cent mortality rate and with remarkable clinical improvement in the majority of their cases.

The approach to the mitral valve is through the left atrial appendage after a purse string has been applied to control bleeding. If the valve leaflets cannot be separated sufficiently by digital pressure, various types of knives have been devised to cut the tough, scarred and fused valves at their commissures. The same is true for the occasional case of tricuspid stenosis.

Patients with mitral stenosis are placed in one of four classes:

Class I is essentially the group with a murmur but without symptoms

Class II is the group in which there is some decrease in exercise tolerance but no evidence of heart failure or appreciable limitation of activities

Class III is the group in which the condition has definitely deteriorated and there is evidence of pulmonary edema

Class IV is the group in which the condition is far advanced with more or less chronic heart failure

It is obvious that class III is the ideal group upon which surgery should be performed. The cases selected for surgery are those without appreciable mitral insufficiency and without other associated valvular lesions.

In 42 of the 45 cases of mitral commissurotomy in this series the patients were females. There were 5 deaths. Two were operative deaths, and the other 3 were due to progression of the disease. In most of the other cases the patients are noticeably improved objectively and subjectively, and the majority of them have returned to their former work (fig. 5).

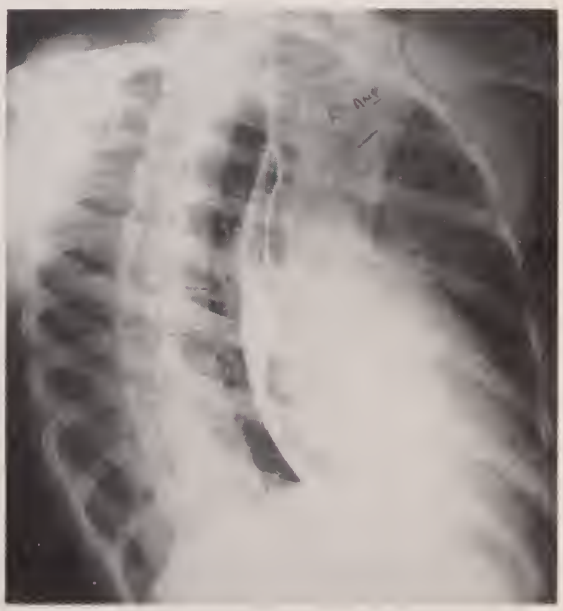


Fig. 5. — Mrs. S. T. Mitral stenosis. Right anterior oblique roentgenogram reveals enlargement of the outflow tract of the right ventricle, enlargement of the right ventricle and encroachment upon the barium-filled esophagus by the enlarged left atrium.

Aortic stenosis is more difficult to correct surgically, and a completely satisfactory technic has not been devised. Bailey believes that with his most recently devised instrument better results should be forthcoming. It is to be realized, however, that the operation is a blind procedure through the left ventricle. Swan is experimenting with a more direct approach with the use of an artifical operative tunnel sutured to the aorta. Probably satisfactory correction of this defect will have to await perfection of extracorporeal circulation or its combination with hypothermia and use of the transaortic approach to the valve. In a few reported cases combined aortic and mitral stenosis have been corrected concomitantly.

Valvular insufficiency has met with especially poor results from the standpoint of attempted surgical correction. The chief efforts in this direction have been put forth by Bailey and Harkens; however, the methods proposed by them have not met with any considerable degree of success. In aortic insufficiency, Hufnagel is using a prosthetic valve in the aorta distal to the arch vessels. Early results show some promise, but it seems unlikely that this will be the solution to the problem of aortic insufficiency. The procedure has been complicated by peripheral embolization.

In cases of repeated peripheral embolization thought to be arising from the left auricular appendage, some authors suggest removal of the appendage. Others believe this procedure is of little value, and the statistical results are conflicting.

Myocardial Ischemia. — It is an accepted fact that a major cause of death in men of the middle age group is myocardial vascular insufficiency.

Since it is not possible to prevent coronary disease, much effort and time have been devoted to devising operations to increase the blood supply to the myocardium. For some 20 years Beck has been evaluating various surgical procedures for the palliation of this condition. Unfortunately, his procedure of arterialization of the coronary sinus with retrograde circulation of arterial blood through the venous system of the heart has not proved of enough value to justify the associated operative mortality. Its originator was most enthusiastic about it for some time, but he has now abandoned it. At the present time he is evaluating the combination of partial ligation of the coronary sinus and asbestos poudrage or pericardiopexy. Thompson is most enthusiastic about the use of magnesium silicate (U.S.P. Talc) in the pericardium to produce chronic hyperemia of the myocardium and adhesions between the pericardium and myocardium. He believes that his early and late results in approximately 150 cases are such as to justify continuation of the procedure. Vineberg approached the problem by transplanting an internal mammary artery into the wall of the left ventricle with the establishment of anastomotic vessels.

All of these procedures must be evaluated further, and more time must elapse before one can be sure of their true place in the treatment of coronary artery disease. It is doubtful that increasing blood supply to the myocardium with any of these presently proposed procedures will prove to be of great value. The use of Talc within the pericardium according to the technic of Thompson is a simple procedure carrying little risk and may be worth while in the severely handicapped.

The selection of cases is most important. The indications are: (1) pain on exertion; (2) one or more coronary arterial occlusions; (3) some physical incapacity; and (4) failure of adequate medical management. Contraindications are: (1) pronounced cardiac enlargement; (2) dyspnea at rest; (3) cardiac failure; (4) recent infarction; (5) hypertension of considerable degree; and (6) age 65 or above. Thompson reported good results in 70 per cent of his cases with an operative mortality rate of 16 per cent.

Aortic Aneurysms. — The majority of thoracic aneurysms are of syphilitic origin. This type of lesion is encountered with decreasing frequency at the present time because of antisyphilitic therapy. Syphilitic aneurysms probably eventually will become a rarity. As longevity increases, however, there probably will be an increasing number of arteriosclerotic aneurysms. It is usually considered that the average period of time from onset to death in aortic aneurysms is less than one year. Some patients have been known to live for many years without treatment. In 1 of my cases the patient lived 15 years after the aneurysm eroded through the sternum.

Many efforts to correct this condition have been devised or attempted. Blakemore brought about progressive constriction by wiring and the use of electric coagulation. The application of "polythene" about the aneurysmal sac in order to bring about a constricting or limiting layer of scar tissue has met with some success. Recently

two other approaches to the problem have been used: (1) use of arterial homografts to replace the area of the aneurysms, and (2) removal of the saccular aneurysm and lateral repair of the aortic wall. Surgeons who have done most of this work are Hufnagel and Eastcott, Gross, Coleman, Deterling and Parshley, Cooley and DeBakey, and Bahnson. These procedures are meeting with some success, but as with all new procedures, much additional time is necessary for proper evaluation.

My experience with aneurysms of the thoracic aorta from the standpoint of surgical treatment has been limited to a few cases. In only 1 case was the aneurysm resected. The patient was a 35 year old man whose reaction to serologic tests was negative. A saccular aneurysm of the ascending aorta of moderate size was removed with lateral repair of the aorta. He is alive and working six years after removal of the aneurysm. To my knowledge, this is the first successful removal of an aneurysm from the ascending aorta.

Of the procedures discussed, all have some merit, but the one which has the most clinical application at the present time is the removal of saccular aneurysms of the thoracic aorta with lateral repair of the wall of the aorta. After further technics have been perfected, removal of the section of the aorta containing the aneurysm (distal to the arch), and the use of homologous grafts probably will become the best operation.

Tumors of the Heart. — Fortunately, tumors of the heart are rare, and in most of the few reported cases they have been either myxomas or sarcomas. Small benign tumors of the heart, if discovered before they are extensive, may possibly be removed. In all probability no cures will result from removal of malignant tumore of the heart. My experience has been limited to 1 case, that of a 27 year old man with sarcoma of the heart, which terminated fatally in three months.

Tumors of the Pericardium. — A few benign and malignant tumors of the pericardium have been encountered. My only personal experience with tumors of the pericardium has been confined to pericardial cysts. I have seen 7 pericardial cysts. They need not be operated upon unless they assume a large size, produce symptoms, or are confused with other lesions making exploration necessary as a diagnostic procedure (fig. 6).



Fig. 6. — Mrs. I. T., a Negro woman, aged 23. Pericardial cyst, filled with hemorrhagic cloudy, gelatinous fluid.

Cardiac Arrest. — There is no greater tragedy or catastrophe from the standpoint of the surgeon, the anesthetist, the family and all other persons involved than the occurrence of sudden unexpected death on the operating table due to cardiac arrest. This is especially true if one is operating upon a good risk, healthy person and one with a comparatively minor disease. It is one of the few grave emergency complications arising during surgery or anesthesia. Its apparent increase and the unknown etiology should prove a

real challenge to the anesthesiologist. Every surgeon should familiarize himself with cardiac resuscitation.

There are two types of so-called cardiac arrest. First and most common is cardiac standstill, which, in my experience, has occurred in diastole with pronounced filling and engorgement of the heart. The second is ventricular fibrillation. The early management of the two is identical. Whatever is done must be done within three to five minutes because cardiac function restored after that period of time seldom will result in survival of the patient. It is unwise to lose time through prolonged listening to the heart, ordering an electrocardiogram and injecting medicines into the heart through the intact wall of the chest.

2. An immediate thoracotomy with exposure of the heart and rhythmic compression of it
3. Adequate administration of blood, plasma, and/or other fluids during the resuscitative process

All three of these procedures should be carried out simultaneously by different members of the operating team. The anesthetist should be alert to recognize cardiac arrest immediately and transmit the information to the surgeon. He in turn should promptly proceed with his portion of the resuscitation, and the operating room nursing staff and/or the house staff should be getting fluids into the patient at the same time (fig. 7).



Fig. 7. — Autopsy demonstration of cardiac massage or resuscitation. A. Tape marker shows line of incision in the left fourth anterior interspace. B. Pericardium has been incised, and the apex of the heart lies in the palm of the left hand. The heart is then rhythmically compressed.

The following plan seems to be a satisfactory one:

1. Establishment and maintenance of an adequate airway, which should be in the form of an endotracheal tube through which oxygen is administered

Cardiac massage can best be performed, in my estimation, intrapericardially by incising the pericardium longitudinally, placing the hand in the pericardium and letting the apex of the heart rest in the palm of the hand as the heart is rhythmically compressed 60 to 80 times per min-

ute. If the surgeon is operating in the abdomen, it may be faster for him to go through the diaphragm and directly into the pericardium in that manner. Compression of the abdominal or thoracic aorta distal to the arch during the process of massage will be of considerable value in keeping a satisfactory blood pressure in the coronary arteries and in the blood vessels of the brain.

Drug therapy is of secondary importance. Usually the heart will resume its own contractions after a few minutes. If ventricular fibrillation persists, a defibrillator should be used. The most effective treatment for fibrillation is the production of complete standstill of the heart by electrical stimulation varying from 110 to 175 volts at from 1 to 3 amperes for one-tenth second. The amperes should be reduced with higher voltages, and the higher voltages are used with the larger hearts. The first shock should be extremely brief. The heart in fibrillation that becomes defibrillated to a standstill is then compressed to bring it back to normal spontaneous contraction. Injection of 10 cc. of a 1 per cent solution of procaine into the left ventricle may be helpful in ventricular fibrillation. Calcium chloride is contraindicated in ventricular fibrillation as is also barium chloride. Epinephrine, barium chloride and calcium chloride may be used in asystole or when the heart contraction is weak.

After cardiac arrest has been corrected, the thorax is closed in the usual manner with an underwater drainage tube left in the chest for 24 to 48 hours. I have had 12 cases of cardiac arrest. In 11 the arrest occurred in patients who were being operated upon or were about to be subjected to operation. There were 8 survivals without residual sequelae. Of the 4 deaths, 3 are unexplained while the fourth was due to prolonged anoxia prior to recognition of cardiac arrest. Two of the 3 unexplained deaths occurred after pneumonectomy as the wound was being closed. The anesthetist had experienced difficulty keeping the patients properly oxygenated during the procedure, and it seems likely that death was due to hypoxia. The third death occurred in a 70 year old man with carcinoma of the cervical esophagus who was undergoing the first stage of a Wookey type resection. The skin flap on the neck was being reflected shortly after administration of the anesthetic was started when cardiac arrest occurred. The heart was found to be in standstill, but fibrillated promptly each time heart action was resumed. It was defibrillated each time, but this procedure repeated itself over a period of three hours, and the patient succumbed. Only by adequate and repeated rehearsal by every member of the team can a high percentage of patients with cardiac arrest be resuscitated. Many of the deaths are preventable.

Unsolved Problems and Experimental Work

There are a number of cardiac defects which are not compatible with life for any appreciable length of time. These will probably never be corrected, and discussion of the problems they present does not come within the scope of this paper. It may be possible before too long to correct transposition of the great vessels or anomalous return of the pulmonary veins, Lutembacker's syndrome, Eisenmenger's complex, abnormal origin of the coronary arteries, mitral insufficiency and adequate correction of interventricular septal defects.

Many more surgical measures can be accomplished when extracorporeal circulation is perfected and when investigators have learned more of the use of hypothermia. The widespread use of controlled cross circulation may prove to be a great contribution. As surgeons learn more about these methods, it seems likely that they will use them in various combinations to achieve many of the objectives which are not now possible. Gibbon and his co-workers have worked diligently for years to perfect and improve their extracorporeal heart-lung preparation. Dodrill, Hill and Gerisch have reported succcessful operations in which the left ventricle was bypassed and complete substitution maintained for 50 minutes.

The trend lately has been toward the production of simply machines for taking over a part of the functions of the heart and lungs. Probably the most practical approach is for the machine to bypass part of the heart but to take the blood to the lungs for oxygenation and return it either to the left side of the heart or to the systemic circulation rather than to attempt artificial oxygenation of the blood by a mechanical device.

Summary

A brief discussion has been given on the most commonly encountered congenital and acquired heart defects. Many of the cardiac problems have been solved, some are on the verge of solution, but others will require additional time, effort and ingenuity before a satisfactory solution is reached. Too little has been learned about extracorporeal circulation, hypothermia, and the use of con-

trolled cross circulation during intracardiac surgery. Many of the procedures used today will be replaced by improved measures tomorrow. In this ever expanding field even greater discoveries lie ahead.

This presentation includes a brief review of my experience in the management of 129 cases representing a wide variety of defects and diseases affecting the heart and great vessels.

The assistance of Drs. Charles Bailey and Robert Glover in the early cases of mitral commissurotomy is deeply appreciated, and acknowledgment also is made to my associate, Dr. John G. Chesney, for his support in carrying out these procedures. The National Children's Cardiac Hospital and its staff also have given considerable diagnostic aid and suggestions, which have helped tremendously in carrying out this work. Finally, I wish to acknowledge the help received from a number of physicians who have generously contributed their time.

A complete list of references may be obtained from the author.

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Discussion

DR. HAWLEY H. SEILER, Tampa: I wish to congratulate Dr. Daughtry on an excellent and complete review of this subject in the time allotted. It amazes me that he has been able to cover the field so thoroughly and at the same time present a clearcut picture of the various cardiovascular conditions which are presently amenable to surgery. This field is still in its infancy, of course, and in a few years cardiovascular surgery will be far more extensively employed than at present. Many conditions which are now in the experimental stage as regards surgery will then be subjected to operative correction as the experimental laboratories and large research centers develop further refinements in surgical technic.

Time does not permit a discussion of the many problems covered by Dr. Daughtry, but one or two points will be emphasized. There has been some recent conversation and writing concerning the psychic rather than actual physical benefit derived from the operation of mitral commissurotomy performed for mitral stenosis. I believe that the authors who believe these benefits to be mostly psychic are probably referring to cases in which the surgery was performed on stage I and stage II stenosis according to the classification of Bailey, Glover and O'Neill. As mentioned by Dr. Daughtry, surgery is not indicated in the stage I lesion and is certainly not urgent in the stage II type. In stage I, the patient has no symptoms. The only finding may simply be the typical murmur of mitral stenosis. Surgery is not indicated in this type of case. In stage II, symptoms are minimal, and again surgery is not urgent. It is the stage III group in which the patient has had previous episodes of cardiac failure, hemoptysis, pulmonary edema, and possibly embolic phenomena, in which the operation is of most benefit. When one observes a patient who has been chronically invalided because of mitral stenosis, unable to perform ordinary duties, and is then restored to normal activity and even able to work an eight hour day following commissurotomy, the inference is obvious that there is considerable merit in the operation. On the other hand, when the procedure is performed in the far advanced group, where there is considerable myocardial damage and little hope of salvage, again the results are poor.

The following slides demonstrate the point which has just been mentioned. This patient was in the stage IV category and in chronic failure. You can see from this slide the giant over-all enlargement of the heart with almost aneurysmal dilatation of the left auricle. Although the patient did fairly well following commissurotomy, there was progression of the rheumatic carditis with death six to eight months following surgery. It is useless to try to salvage a patient when there is already such severe irreversible cardiac damage. The next slide shows the heart opened. Viewing through the auricle one may see the enlargement of the mitral valve following commissurotomy. This next slide shows another view of the same finding.

In conclusion, it seems obvious that proper timing is extremely important when surgery is considered for mitral stenosis. The operation has considerable merit when the indications are proper and when it is performed before irrevocable cardiac damage has been done.

Again I wish to congratulate Dr. Daughtry on an excellent presentation.

The 16th annual series of medical district meetings of the Florida Medical Association are scheduled to be held in October. The meeting in District A will be at Pensacola; in District B at Gainesville; in District C at Lakeland, and in District D at Fort Lauderdale.

ACTH and Cortisone in the Treatment of Pulmonary Infection Report of a Case

Louis M. Sales, M.D.
JACKSONVILLE

In the five years or so since ACTH and cortisone have been commercially available to the general medical public, countless thousands of articles have appeared in print regarding their efficacy or lack of effectiveness in a host of diseases. Surprisingly enough, however, little has been written about their use in pulmonary infection other than, of course, a reminder of the hazards of their use in active pulmonary tuberculosis and their ineffectiveness in conditions such as pulmonary emphysema, fibrosis and bronchiectasis, the one exception being the widespread acknowledgment of extremely beneficial effect on status asthmaticus. This is all the more surprising in that the first article[1] on the efficacy of ACTH in pneumonia was contained in the proceedings of the First Clinical ACTH Conference and subsequently expanded by Kass, Ingbar and Finland[2] into an article appearing in the Annals of Internal Medicine in November 1950.

Finland and his group treated 3 patients with pneumonia due to types 8, 2 and 1 pneumococci respectively and 2 with primary atypical pneumonia with pituitary adrenocorticotrophic hormone. Defervescence and relief from symptoms and signs of toxemia occurred promptly in all cases. In 3 instances, the patients remained asymptomatic and afebrile, despite the persistence of bacteremia in 1 and the continued production of rusty sputum in another. One patient with pneumococcal pneumonia experienced an exacerbation of symptoms while receiving ACTH, with remission when the dose was increased. This patient had an extension of his pulmonary lesion, and later empyema developed. One patient with viral pneumonia had a similar exacerbation of symptoms while receiving the hormone, with prompt relief from all symptoms except cough when the dose of ACTH was increased, but with return of fever and malaise after ACTH was withdrawn.

No evidence was obtained in this series of any bactericidal action exerted by adrenal steroids. Antipneumococcal antibodies and cold agglutinins appeared at the anticipated time, with no evidence of acceleration or delay in their production. Eosinophils were uniformly absent in all cases during the acute stages of the illness and returned either after the dose of ACTH was reduced or, as in 1 case, when the patient acquired tolerance to the administered dose of the hormone and "escaped" from its effects. Clearing of the pulmonary lesions may have been accelerated in 1 patient and delayed in another, but in the remaining 3 patients resolution of the pneumonic process seemed to have been neither accelerated nor delayed. All the patients manifested euphoria at some time while they were receiving the drug. Glycosuria developed in 2 and facial edema in 2, and in all some degree of bradycardia was demonstrated, but in none was there any significant alteration of blood pressure or sedimentation rate attributable to the ACTH. The authors concluded that ACTH may, in some instances, induce profound changes in the clinical symptoms of patients with acute infections without demonstrably affecting the etiologic agent. There was no evidence from these cases of any effect on the production of specific antibodies.

Indications that ACTH and cortisone might be equally effective in the treatment of pulmonary infection when given by nebulizer was suggested by Reeder and Mackey.[3] In their case, a white male was given cortisone by inhalation. They concluded that:

(1) In pneumonia cortisone appears to be as effective by inhalation as by parenteral administration.

(2) The reaction of the host to the disease is favorably influenced by this agent.

(3) Bacterial growth is not influenced.

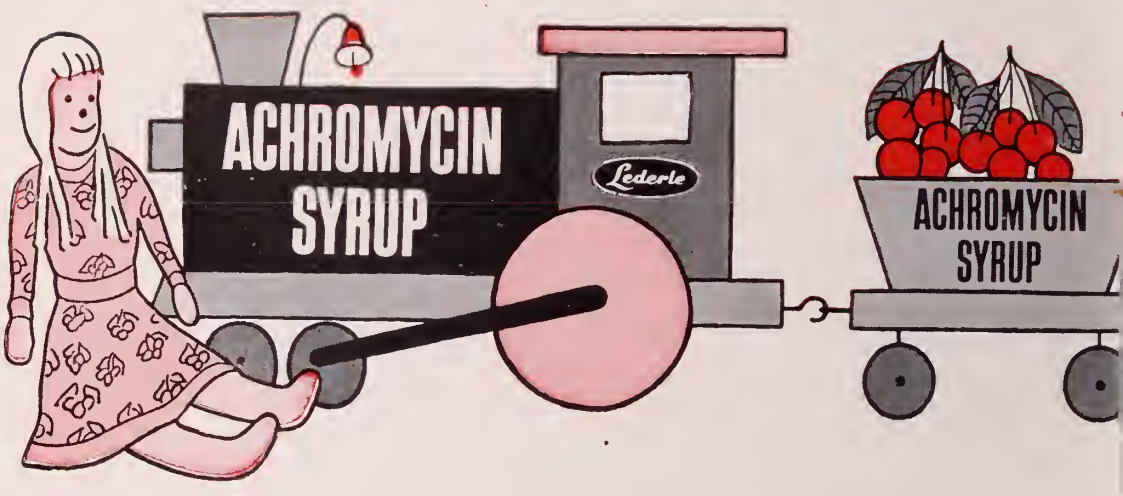
(4) Comfort and security may be accorded the critically ill patient by the use of cortisone.

Glaser, Berry, Loeb and Wood[4] next proceeded to test the effects of ACTH and cortisone in

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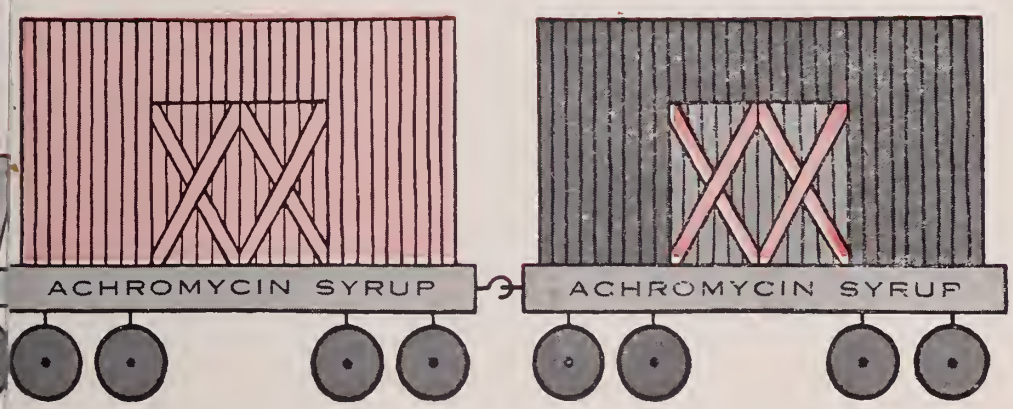
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pneumonia in mice. Their conclusion was that in the experimental animal these agents had no effect whatsoever upon the infectious agent nor the disease process, but if any effect was forthcoming, it was detrimental, if anything. The pneumonic lesion in these animals, when cortisone was administered, exhibited the following differential features:

(1) The edema response was accentuated.

(2) The bacterial population of the infected alveoli was often excessive.

(3) The migration of neutrophilic leukocytes into lesions appeared to be depressed. Of the individual variations these findings were observed; the general differences were relatively consistent. The unfavorable effects of cortisone upon the infection, including the precipitation of early bacteremia, could not be attributed either to an absence of streptococcal growth per se or to a decrease in the number of circulative polymorphonuclear leukocytes. Systematic histologic studies suggested that the detrimental action of cortisone against bacterial disease may be related to an interference with mobilization of phagocytic cells at the site of the infection.

Report of Case

A 32 year old white man consulted me on Nov. 4, 1953, complaining of a febrile illness of 10 days' duration associated with pain in the left side of the chest, a dry nonproductive cough, generalized aching, malaise and dyspnea on exertion. The essential physical findings consisted of a well developed and well nourished acutely ill man, dyspneic at rest and markedly so on any exertion, presenting flatness, absent breath sounds and diminished vocal fremitus over the base of the left lung to approximately the level of the spine of the scapula posteriorly. The remainder of the physical examination gave essentially normal results.

The patient was believed to be suffering from empyema, and hospitalization was strenuously urged, but refused for economic reasons. He was therefore temporarily given penicillin and Terramycin with instructions regarding follow-up study. When he returned the following day, the symptoms and findings were much the same. At this time a diagnostic tap revealed thick, white, foul-smelling pus on aspiration from the left pleural space. Again, despite vigorous urging, the patient refused to be hospitalized even though possible consequences of his actions were thoroughly explained to him.

He returned to the office on November 6, an obviously chastened and greatly frightened young man, who stated that during the previous night in a paroxysm of coughing he had suddenly expectorated a copious amount of foul-smelling sputum and had been running a septic type of temperature curve with alternating chills and fever ever since. Physical examination at this time revealed, as anticipated, obvious evidence of a bronchopleural fistula, and now he readily consented to hospitalization.

When admitted to the hospital, the patient was acutely and even critically ill, running a septic type of temperature with swings from 98.6 to 103 F. daily, having profuse drenching sweats, tachycardia in proportion to the fever, definite and rather pronounced dyspnea and orthopnea, and in general showing the signs of an acute and virulent infection. The pulmonary findings at this time were as already indicated, the remainder of the physical examination giving essentially negative results.

The roentgenogram of the chest on the day of admission was reported as showing an air-fluid level at the base of the left lung, about 4 cm. above the diaphragm and in the posterior third of the thorax, which was thought compatible with a cavity either in the lower lobe of the left lung or in the pleural space, the latter seeming the more likely possibility. A dense infiltration involving all but the apical and the infraclavicular portion of the left lung and similar changes involving the lower two thirds of the right lung with the exception of the costophrenic angle laterally also were noted. These findings in the left lung were thought compatible with either an abscess in the lower lobe or empyema at its base with bronchopleural fistula, while the consolidation in the right lung was thought to represent an aspiration pneumonia. A blood count on the same day showed 66 per cent hemoglobin, or 10.1 Gm., 3.45 million red blood cells and 14,300 white blood cells, with 72 per cent neutrophils, 15 per cent juvenile and 57 per cent segmented forms, 5 per cent eosinophils, 22 per cent lymphocytes and 1 per cent monocytes. Urinalysis at this time gave essentially negative results except for a somewhat low specific gravity, as was also the case on examination the following day. On November ninth, fourteenth and sixteenth, respectively, examination showed the hemoglobin being maintained with the aid of blood transfusions at 84 Gm. per hundred cubic centimeters and a gradually rising red blood cell count of 4.2 to 4.9 million while the white blood cell count ranged between 13,000 and 17,200 and the polymorphonuclear leukocyte count between 60 and 83 per cent. A final white blood cell count on November 16 showed a drop to 13,750 cells and a decrease in the polymorphonuclear leukocytes to 61 per cent.

On admission, the treatment instituted consisted of antibiotics, 600,000 units of penicillin every 12 hours, alternating with 2 cc. of Combiotic in between, and Terramycin, 500 mg. every six hours; oxygen as needed for dyspnea, and codeine for the relief of pain and respiratory distress. On the day following admission, the respiratory rate was between 40 and 50 and the pulse range between 120 and 150 per minute. The patient was cyanotic and extremely dyspneic and orthopneic. There was obvious definite evidence of a superficial thrombophlebitis of the left saphenous vein. The left side of the chest was tapped; approximately 200 cc. of fetid pus was removed, and 200,000 units of crystalline penicillin was instilled into the chest cavity. On subsequent culture the removed fluid was found to be loaded with white blood cells and aerobic streptococci. The patient was given 500 cc. of blood that day, and the administration of dicumarol was begun. His left leg was kept elevated on a pillow, and intravenous nourishment in the form of Aminosol with glucose was given because of the poor intake of food by mouth.

By November 9, two days after admission, the patient looked bad indeed. There was obvious evidence of a diffuse pneumonic consolidation involving both lungs. A presystolic gallop rhythm was present, and on aspiration of the left pleural space another 150 cc. of foul-smelling pus was removed and replaced by 200,000 units of crystalline penicillin. Terramycin was increased to 500 mg. every four hours, penicillin to 1,200,000 units every six hours, ½ Gm. of Benemid was given by mouth every 12 hours to maintain the penicillin blood level, and oxygen was administered by tent between 11 and 12 liters per minute. Penicillin also was given by aerosol method, 100,000 units per cubic centimeter three times a day. The administration of digitalis in the form of intramuscular Digalen was begun. A second pint of blood was also administered the same day.

The course was progressively downhill, and on November 10 the middle and lower lobes of the right lung showed dense consolidation and the left lung much the

same status as previously. The liver was now palpable two fingertips below the costal margin. An erythematous rash developed over the buttocks and legs, which was thought to represent a reaction to penicillin. All in all, it was concluded that a fatality might be expected unless the clinical course could be shortly reversed. Terramycin, 500 mg. intravenously in 250 cc. of distilled water every 12 hours was now given, and at 2:00 p.m. on the same day, cortisone, 50 mg. orally every four hours, also was begun. Thoracentesis at this time resulted in the removal of an additional 100 cc. of thick purulent material in addition to large amounts of thick, extremely foul-smelling yellow pus which the patient was raising in copious amounts by mouth. By 8:00 p.m. that night, approximately two hours after the second dose of cortisone was administered, the temperature, pulse and respiration had declined to normal, and they remained there until the patient was discharged.

The following day the patient appeared markedly improved. The dyspnea was considerably less, and the amount of sputum being expectorated had diminished. The gallop rhythm of the heart was gone, and he felt much better in general. He continued to manifest this improvement throughout the remainder of the hospital stay.

By November 12 only a small amount of purulent material could be obtained by aspiration of the left side of the chest. Expectoration of purulent material had greatly decreased. The right lung showed at least 50 to 60 per cent clearing. The left lung also showed a considerable degree of clearing. A roentgenogram of the chest at this time confirmed the clinical impression. It was interpreted as follows: "Re-examination of the chest in the anteroposterior projection at the bedside with the patient supine revealed definite improvement as compared with the films of November 11, 1953. Cavity with fluid level cannot, of course, be excluded without films made with the patient erect. The density in the lower two thirds of both lungs, however, has diminished considerably although residual consolidation is still present. More improvement has occurred on the left side than on the right."

The left lung on November 15 showed only a small fluid level on physical examination, and both lungs were almost completely clear on auscultation and percussion. The pulse was now 80; the heart sounds were of good quality. The condition in general was good, and only the thrombophlebitis of the left leg failed to show any improvement. Intravenous fluids had been stopped on November 13. Digitalis had been reduced to 1 cat unit daily by mouth on that date, cortisone to 25 mg. every six hours, aureomycin to 500 mg. every six hours, and penicillin to 1,200,000 units twice a day. On November 15 pencillin aerosol was discontinued and cortisone reduced to 25 mg. every eight hours. Oxygen was stopped entirely, as also was the digitalis. By November 17 Benemid was discontinued; Terramycin was reduced to 50 mg. every six hours and cortisone to 12½ mg. every six hours. The patient was allowed in a wheel chair. At this time only a small fluid level remained in the left lung by physical findings, and thoracentesis resulted in the removal of only approximately 40 to 50 cc. of pus, which was replaced by penicillin as on previous occasions. The lungs otherwise on physical examination appearcd almost completely clean, and the remainder of the physical examination gave negative results with the exception of the thrombophlebitis of the left leg, which did show some signs of resolving under continued dicumarol therapy.

A final roentgenogram of the chest on November 18 demonstrated a small fluid level still present at the base of the left lung posteriorly just above the diaphragm, which, however, was definitely less extensive than before and which was accompanied by great improvement in the over-all appearance although some residual consolidation was still thought to exist at the bases of both lungs. At this time cortisone was again reduced to 12½ mg. every eight hours.

On November 19 the patient was discharged from the hospital although he was still taking small doses of cortisone and Terramycin and some swelling and inflammation of the left lower extremity were still present. He was seen again in the office on November 20, 23 and 25. During this period of observation he continued to show steady and progressive improvement in general although some slight signs of consolidation at the bases of both lungs still persisted by clinical findings and although the thrombophlebitis was still present but in greatly diminished degree. Unfortunately, he was lost from observation thereafter, and further follow-up became impossible.

Discussion

It must be admitted that the evidence in this case is not as clearcut as one would wish it to be. It is conceivable that the continued use of large doses of antibiotics finally might have produced the desired results and that the patient began to improve just at the time cortisone was added to the armamentarium. It is also possible that the addition of intravenous Terramycin to the dosage schedule at approximately the same time may have been the additional factor responsible for the resultant change for the better. The evidence, however, is too strong for it to be coincidence that this patient should have continued to pursue a rapidly downhill course despite heroic doses of various antibiotics and that this downhill course should have been halted abruptly following the administration of cortisone. In any event it cannot be denied, as is already well known, that cortisone or ACTH may prove a life-saving measure in the face of what otherwise would be an overwhelming and fulminating infection, and despite inclusive evidence for the beneficial effect of cortisone in pulmonary infection from an experimental basis, empirically it appears that there are times when its use is strongly indicated.

Summary

There is presented a case of fulminating pulmonary infection due to aerobic streptococci with strong clinical evidence of a favorable and even life-saving response to the administration of cortisone.

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Abstracts of Medical Articles

Suppression of the Manifestations of Gout with Continuous Cortisone Therapy. By Augustus E. Anderson Jr., M.D. Am. J. Med. 16:292-294 (Feb.) 1954.

That cortisone can be effectively employed for a prolonged period in the therapy of gout is indicated by the case reported here. Suppression of acute arthritic attacks and mobilization of solid, presumably tophaceous, deposits in a patient with gout by the prolonged daily administration of cortisone is described. Increasing effectiveness of the drug with the passage of time was observed over a period of 22 months.

The Tonsil Problem in Review, Some Concepts, Comments and Conclusions. By A. R. Hollender, M.D., F.A.C.S. Eye, Ear, Nose & Throat Monthly 33:44-49 (Jan.) 1954.

The author analyzes present thinking, inventories current knowledge, and reviews special phases of the tonsil problem as a whole. He observes that the conclusions should suggest existing deficiencies, in anticipation that investigators will at once see the fertile field still to be explored. In summary, he comments that indecision regarding the functions of the tonsils will continue until the precise nature of lymphoid tissue is determined. The bacteriology of the tonsils, however, both in health and in disease, is well known, the nasopharynx especially, and the faucial tonsils, constituting the bacterial centers of the respiratory tract. In recent years, the fallacies of the focal infection concept have been repeatedly pointed out, though there is some basis for the belief that the lymphoid structures of the pharynx play some secondary role in the production of certain systemic diseases.

Medical management of acute tonsillitis embraces, in addition to the older conventional measures, administration of the newer antimicrobial agents, which have substantially improved the prognosis. For chronic hypertrophic tonsillitis, a well performed tonsillectomy remains the therapeutic method of choice, indictment of the procedure as a failure by a few laryngologists being based purely on technical grounds. In selected cases unsuitable for tonsillectomy, roentgen ray therapy has proved the ideal substitute.

Upper Urinary Tract Disease Associated with Urethral Stricture. By J. Denny Moffett Jr. and David W. Goddard. J. Urol. 72:293-295 (Sept.) 1954.

In this study of the upper portion of the urinary tract in 125 consecutive cases of urethral stricture in men, there was evidence of disease of this tract in more than one third. In less than 15 per cent, however, of the cases in which there was demonstrable disease at this site were there symptoms suggestive of a lesion. The most important complications were renal calculi (16.0 per cent), hydronephrosis or hydroureter (24.0 per cent), pyelonephritis (13.6 per cent), and pyonephrosis (1.6 per cent). Their investigations led the authors to conclude that disease of the upper portion of the urinary tract is associated with urethral stricture in men in a large percentage of cases and that the absence of symptoms referable to this part of the tract in the presence of disease there is a striking feature in cases of this type. They noted that the longer the duration of the stricture, the greater is the frequency of lesions in the upper portion of the urinary tract. Adequate treatment of the stricture, they added, is of prime importance in the prevention of damage to this part of the tract, and they observed that the number of patients who receive adequate treatment is discouraging. It was their conclusion that acute urinary retention, periurethral abscess, and phlegmon occurring with urethral stricture contribute to a great increase in disease of the upper part of the urinary tract, and they advised investigation of this portion of the tract in every case of urethral stricture for proper evaluation and management.

Histochemical Changes in Irradiated Ovaries. I. Succinic Dehydrogenase Activity. By Alvan G. Foraker, M.D., Sam W. Denham, M.D., and M. Harlan Johnston, M. D. A. M. A. Archives of Pathology 55:147-153 (Feb.) 1953.

In this study the left ovaries of 12 rabbits were subjected to external 200 kvp irradiation for a single dose of 400 r. Four weeks later 6 of the rabbits were used in negative and 6 in positive Friedman tests. Tissue from all ovaries was incubated in neotetrazolium with succinate to demon-

strate succinic dehydrogenase activity. The result showed:

1. Little evidence of irradiation damage to stromal cells, either in general pattern or in succinic dehydrogenase activity, as manifested by formazan deposition in irradiated and nonirradiated ovaries.

2. Obliteration of most of the ova in irradiated ovaries. Those remaining were largely atretic, with little follicle-cell formation.

3. Little evidence of ability of the irradiated ovaries to respond to the hormonal stimulation of the Friedman test.

Histochemical Changes in Irradiated Ovaries. II. Carbohydrate and Lipid Localization. By Alvan G. Foraker, M.D., Sam Wesley Denham, M.D., and M. Harlan Johnston, M.D. A. M. A. Arch. Path. 57:30-35 (Jan.) 1954.

This report records a continuation of histochemical studies in irradiated ovaries. The left ovaries of 12 rabbits were subjected to 200 kvp irradiation for a single dose of 400 r. Four weeks later 6 of the rabbits were used in negative and 6 in positive Friedman tests. Tissues from all ovaries were stained with the periodic acid stain to demonstrate glycogen and other periodic acid-positive substances and with Sudan black B to demonstrate lipid. The results showed little evidence of irradiation damage of the stromal cells either in pattern or in lipid content; obliteration of many of the ova in irradiated ovaries, those remaining being largely atretic with no stainable lipid and with a considerable deposition of a periodic acid-positive substance,, not glycogen; little evidence of ability of the irradiated ovaries to respond to the hormonal stimulation of the Friedman test.

Analysis of the Electrocardiograms Obtained from 1000 Young Healthy Aviators; Ten Year Follow-up. By Lt. John M. Packard, MC, USN, John S. Graettinger, M.D., and Capt. Ashton Graybiel, MC, USN. Circulation 10:384-400 (Sept.) 1954.

In this study 96 per cent of the original subjects were traced after a period of 10 to 12 years. Of this number 202 were dead, 193 from trauma, 7 from disease, and 2 from unknown cause. Only 1 died of heart disease (myocardial infarction), and his electrocardiogram had been normal in 1941. Of 703 men re-examined, in only 4 was there objective evidence of heart disease: coronary heart disease with myocardial infarction in 1, hypertensive heart disease in 2, and cor pulmonale in 1. In 8 there was roentgen evidence of enlargement of the heart as the only indication of heart disease, and in 12 others a blood pressure greater than 145/95 mm. Hg was associated with otherwise normal findings.

The data obtained on re-examination were complete for 639 men and were subjected to statistical analysis. The effect of change in heart rate, age, weight, and blood pressure on these electrocardiographic measurements is discussed. Ranges of normal varying only slightly from those suggested by other authors are proposed on the basis of these findings. Both in the normal electrocardiograms and those in the borderline zone between normal and abnormal there was a wide range of measurements in these healthy men, but in the individual cases the change over a 10 year period was relatively slight. In the light of these findings the reliability and validity of the electrocardiographic method is discussed.

Except in 1 case of myocardial infarction, subjects with "borderline" or frank electrocardiographic abnormalities showed no symptoms of the development of heart disease. It is argued that the borderline abnormalities, considered as a group, must have little pathologic significance; otherwise, out of the relatively large number of subjects in this group, some would have exhibited symptoms. Although heart disease did not develop in any of the subjects with frank electrocardiographic abnormalities, such as bundle branch block, the same argument does not hold with equal force because of the small number of cases in that group.

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Vaccine Hullabaloo

Highest traditions of selfless and humanitarian ideals appear to have been maintained in medical research work leading to recent brilliant developments of "Salk Vaccine," an agent effective in preventing the increasingly frequent and virulent virus disease, poliomyelitis.

From the time of Landsteiner and Popper's work half a century ago, whereby the virus was successfully transmitted to and then isolated from monkeys, until 1949, when Enders and his associates[1] demonstrated a method of cultivating the virus in the laboratory on human and monkey mediums other than nerve tissue, work was painstakingly slow and discomfortingly meager. The recently reported success of Jonas Salk[2,3] and others[4,5] in stimulating and maintaining in man active immunity against poliomyelitis by vaccination with nonliving virus appears to mark a major milestone in medicine. Release under dramatic circumstances of scientifically controlled human study reports confirming Salk's outstanding work raised public interest to fever pitch. The more recent release of data indicating that some batches of commercial vaccine may have been defective opened the floodgates of emotion.

Editors, reporters, feature writers and columnists have had a field day. Apparently most have tried to be fair, but intense public interest and demand for news, temporary lack of authoritative information, hindsight, the let-me-tell-you-what-is-wrong and the I'll-fix-it men apparently have not helped clear, but have added to the confusion. Highly vocal critics, who at first spoke knowingly of unnecessary delays, inequitable distribution and black market, later discussed improper manufacture of material and its premature release. Some would have us establish federal control to insure proper distribution and control black market development, forgetting that politicians sometimes consult electoral rather than scientific data, and further forgetting that in the past, establishment of police power in the federal government during time of war sometimes has promoted and not prevented black market activity. Some would tell us why and how federal control would make the product safer and better protect the public inter-

est. And all of this from some who apparently do not know the difference between vaccine and serum.

It is our opinion that President Eisenhower has taken a fair, statesman-like attitude toward the whole difficult problem from the first. His advisers seem to be qualified and appear to be doing their level best under the circumstances.

Four facts would seem to be clear: (1) manufacture of the vaccine even with the know-how and proper patience is attended by some risk; (2) when dealing with human lives scientists must and will strive for maximum protection and minimum risk; (3) there is urgent need and huge demand for the vaccine and (4) for a while there will just not be enough to go around. Perhaps it is time now for self-appointed critics and special pleaders to fall silent while physicians, scientists and qualified workers get on with the work.

1. Enders, J. F.; Weller, T. H., and Robbins, F. C.: Cultivation of Lansing Strain of Poliomyelitis Virus in Cultures of Various Human Embryonic Tissues, Science 109:85-87 (Jan. 28) 1949.
2. Salk, J. E.: Recent Studies on Immunization Against Poliomyelitis, Pediatrics 12:47-82 (Nov.) 1953.
3. Salk, J. E., and others: Studies in Human Subjects on Active Immunization Against Poliomyelitis, J.A.M.A. 151: 1081-1098 (March 28) 1953.
4. Howe, H. A.: Antibody Response of Chimpanzees and Human Beings to Formalin-Inactivated Trivalent Poliomyelitis Vaccine, Am. J. Hyg. 56:265-286 (Nov.) 1952.
5. Milzer, A., and others: Immunogenicity Studies in Human Subjects of Trivalent Tissue Culture Poliomyelitis Vaccine Inactivated by Ultraviolet Irradiation, Am. J. Pub. Health 44:26-33 (Jan.) 1954.

Practical Program of Public Relations
Five Major Aspects

Undoubtedly, medicine's new interest in public relations has a complex background, rooted in the changing trends of the present era. Physicians, from top echelons to grass roots, hear much and have the opportunity to read even more nowadays about public relations of and for medicine. In the foreword of a recent excellent book by Mr. James E. Bryan entitled "Public Relations in Medical Practice," which was reviewed in the June issue of The Journal, Dr. Louis H. Bauer, speaking from the vantage point of long observation of world medicine, says, "There is no question that the public relations of the medical profession can stand much improvement." And in his preface Mr. Bryan has a tenable thesis, "The witnesses are many who proclaim that the doctor of medicine stands in need of better public relations . . . yet, even now . . . it is not easy for me to say, in short and simple words, why this should be so."

In his sympathetically conceived, well executed book, Mr. Bryan arrives, inevitably no doubt, at the conclusion "that public relations for the doctor may be summed up as a matter of attitude. . . . His knowledge of physic, his acumen, and skill in administering the marvelous scientific armamentarium that his forebears have bequeathed him, will profit him and his patient little indeed if his spirit is not made humble and his hand made gentle by human compassion." Long ago, Osler unwittingly defined public relations adequately for his profession in these words, "The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will exercise equally with your brain."

Public relations is of course not the whole answer to public misunderstanding of the doctor and the profession. Nevertheless, it is a procedural guide of great value. It seems timely, therefore, to present the major practical aspects of the positive public relations program of the Florida Medical Association in a series of five monthly editorials, of which the one that follows is the first.

I. Medical Care for All

The primary aim of the medical profession is to render service to the public. The patient should feel that his physician is a friend and confidant, that he is not just a number or a trivial incident in the doctor's life. The individual physician becomes then the foundation upon which medical public relations is built. His character and acts determine largely the attitude of the public toward the profession. Public relations obviously has no inherent value in itself. No public relations bureau, county, state, or national, can originate; it can only disseminate what the individual practitioners are and do.

Public relations, therefore, cannot be manufactured, nor derived from any source other than the individual. It is an approach which has been likened to old time evangelism, for it spreads the medical gospel to the people. Its mission is to put into proper perspective the doctor-patient relationship for each and all and to keep it in balance. From the medical standpoint, it is public service—public service translated into rendering good medical service 24 hours a day 365 days a year.

It may be said, then, that public relations is a way of thinking translated into action. The plan of action adopted by the Association's Bureau of Public Relations seeks to provide medical care for all as its primary objective through eight separate channels which the individual members of

the Association will wish to keep ever in mind.

All component county medical societies are urged to promote programs to insure a physician's and a surgeon's care to every citizen in the community. Great strides have been made in this direction in Florida as elsewhere in the nation.

Every effort is being made to expand the network of emergency call services, in some form, to provide the people of every community with the services of a physician in an emergency. The plans in operation vary widely according to the size of the community, but they all have the same purpose — to guarantee the services of a doctor at any time of the day or night, any day of the year. In a state like Florida with its many thousands of visitors, winter and summer, who are many miles from their family doctor, this service takes on added importance.

Everybody should have a family doctor — even the doctor and his family. A particularly valuable public relations project is to promote the concept of a personal physician, so that everybody may have someone to accept total and continuing responsibility for administering or securing and supervising care of medical and surgical problems.

Public relations has a liaison role in promoting cooperation between members of the Association and the various agencies which make medical care available to public assistance beneficiaries and to the borderline group frequently referred to as the medically indigent. This activity enables the profession to participate broadly in sponsoring with these agencies the various types of programs essential to this phase of medical care for all.

The helping hand of public relations is having a vital part in promoting the expansion of hospital facilities in communities throughout the state where deficiencies exist. The hospital program in Florida is forging ahead to meet the ever increasing public demand for hospital accommodations suitable and adequate for all.

Active aid to communities trying to attract physicians is a feature of public relations work that has brought gratifying results. The ultimate goal is to give every area access to the services of a physician.

The improvement of rural health is an important objective which is being attained through encouraging individual and community action. Efforts to help the respective communities determine and solve their health problems with the resources available constitute a perennial public relations challenge which meets with increasing success.

Last, but by no means least, the public relations program of the Association, in its efforts to further the basic objective of medical care for all, cooperates in developing strong fearless grievance committees who hear patients' complaints and, when necessary, do not hesitate to discipline the few who bring discredit on the Association and the entire profession.

Every member of the Association is invited to take stock of his role in this basic program of medical care for all. Public relations is you, Doctor. A constant consciousness of this fact should guide you in all your relationships with your patients and your community.

Tips to Readers of Medical Stories

Many a doctor would like to prescribe free advice for his patients on how to read it when they confront him with a medical story fresh from a current magazine or newspaper. Aware of the general reaction of the members of the medical profession to this not infrequent practice on the part of patients, a noted science writer offers tips to the readers of medical articles in lay publications. Alton Blakeslee of the Associated Press, who is president of the National Association of Science Writers, offers these suggestions:

"The reader must train himself to read objectively — just as he would in reading about politics. First, he should read all the qualifications in the story. He should notice whether experiments have been done only on animals. The stage of development of a cure is important. How extensively has it been used? In how many cases? If it has been tried on only five or six patients, his doctor will not want to make him a guinea pig.

"Secondly, he should notice the source of the story. Does it come from a reputable medical authority? If in doubt, he can ask his local medical society.

"Finally, he should consult his own doctor, who can judge whether a reported new cure would be applicable in his case."

From one layman to another, this is good medical advice. The need for restraint in reading the wealth of medical material flowing from lay publications could not be stressed at a better time than now.

1. Advice on How to Read It, Newsweek, May 30, 1955, p. 50

OTHERS ARE SAYING

Professional Neglect

Despite some statements to the contrary, American medicine is successful, and with its success the American doctor is successful. Maybe much *too* successful for his own good. William Faulkner, in his acceptance of the National Book Award, suggested that perhaps one of the things wrong with this country is "success." "There is too much success in it. Success is too easy. It can be gained so quickly and easily that the young man has not had time to learn humility, to handle it, or even to discover it, or to realize he will need humility."

Fifty years ago William James also sounded the warning with deep conviction and more direct word, when he wrote to H. G. Wells, "The moral flabbiness born of the exclusive worship of the bitch-goddess Success, that with the squalid cash interpretation put on the word Success, is our national disease."

Such a type of success in the physician can produce a certain amount of intellectual strabismus; a sort of squinting and winking at fact and truth, and thus result in neglect of one's professional responsibilities.

All about us there is a great public hunger for the doctor who will give information on matters of health, about disease and its care and treatment. This public knows of the success of the "wonder drugs," of the increase in the span of life, of the healthful "American way of living." He asks his physician, "What about it? What is my disease? What is its name? What is it caused by? Will it get well? How is it treated? Will the wonder drugs help? Where can I get information? Where can I get the best treatment? How much will it cost? Is there any research being done on my disease? Do you doctors really know anything about disease?" Anxious people, all wishing answers, help and consolation but above all consideration.

But what do they sometimes get from their busy successful doctor? "I am too busy — I have no time to lecture you on this subject — just do as I tell you — you will be all right!"

There is a great need for the physician, glowing in such scientific success, to take more time to explain these things to his patient. His patient today is more literate, more informed, sometimes half-informed and often intelligent. He wishes explanations not just pills, "shots," diets, operations and short answers. Many ill patients are incredible "worry-warts" and need intelligent information about, and explanation of, their diseases and discomforts. We must give to them.

Let us not be so blinded by success, and so vulnerable to a little praise, that we become victims of professional neglect. Let us give unto others, by thought, word and deed that which we labored so hard to get. In no other way can we so quickly combat the tremendous love for quackery and pseudoscience which our people seem to have.

Journal of The Medical Assn. of Ga.
April 1955

Medical Officers Returned

Dr. Alpheus T. Kennedy, who entered military service on August 31, 1953, was released from active duty in February, 1955 with the rank of lieutenant, U.S. Navy. His address is 707 North Baylen St., Pensacola.

Dr. Geoffrey H. Binneveld, who entered military service on April 18, 1953, was released from active duty April 30, 1955 with the rank of captain, U. S. Army. His address is 1116 West Main St., Leesburg.

BIRTHS AND MARRIAGES

Births

Dr. and Mrs. Robert A. Shashy of Jacksonville announce the birth of a daughter, Susan Ann, on May 3, 1955.

Dr. and Mrs. William J. Phelan of Jacksonville announce the birth of a daughter, Helen Louise, on May 10, 1955.

Dr. and Mrs. Joseph H. St. John of Jacksonville announce the arrival of a daughter, Katie Ann, in their home.

Dr. and Mrs. Joseph W. Eversole of Jacksonville announce the birth of a son, Stanton Lee, on May 11, 1955.

Marriages

Dr. Oliver D. Anderson of Hialeah and Miss Naomi Head of Miami were married May 5, 1955.

STATE NEWS ITEMS

Dr. I. Leo Fishbein of Miami Beach was in Atlantic City the first of May where he attended the meeting of the American Psychiatric Association.

Dr. Harold W. Johnston of Orlando has been elected president of the Florida Trudeau Society. Other new officers are Dr. Simon D. Doff of Jacksonville, vice president, and Dr. Howard M. DuBose of Lakeland, secretary.

A Post Graduate Course in Pediatric Allergy has been announced by the Division of Graduate Studies of New York Medical College for November 2, 1955 to May 31, 1956. Physicians interested in the course should contact the Office of the Dean of the College, Fifth Avenue at 106th Street, New York 29.

Dr. C. Ashley Bird of Jacksonville was principal speaker at the meeting of the Glynn County Medical Society held May 16 at Brunswick, Georgia. His subject was "Neurosurgical Problems."

Dr. John D. Milton of Miami, president of the Florida Medical Association, addressed the annual meeting of the American Pharmaceutical Association at Fontainebleau Hotel, Miami Beach, May 5. Dr. Milton spoke on the interrelationship between pharmacy and medicine.

Drs. James H. Ferguson of New Orleans and M. Michael Sigel of Montgomery, Alabama, have been appointed to the staff of the University of Miami School of Medicine. Dr. Ferguson was formerly Assistant Professor of Obstetrics and Gynecology at Tulane University School of Medicine. He becomes chairman of the Department of Obstetrics and Gynecology. Dr. Sigel was head of the diagnositic unit, Virus and Richettsia Section, Communicable Disease Center, United States Public Health Service at Montgomery. He has been appointed Associate Professor of Bacteriology.

The Tennessee Valley Medical Assembly, sponsored by the Chattanooga and Hamilton County Medical Society, is being held at Chattanooga October 3-4.

Dr. William H. Anderson Jr. of Ocala was the speaker for the regular meeting of District Three, Florida State Nurses Association, held the first of May in Ocala. His subject was eye diseases and eye surgery.

Dr. William D. Sugg of Bradenton presented a paper before the International College of Surgeons meeting the latter part of May in Geneva, Switzerland. He visited Scotland, Austria and other points of historic medical interest on the continent.

Dr. Thomas F. Nelson of Tampa returned from Europe the first of June. While abroad, he attended the meeting of the International College of Surgeons held at Geneva, Switzerland.

Dr. Theodore F. Hahn Jr. of DeLand was guest speaker at the meeting of District 18, Florida State Nurses Association, held the first of May in DeLand. His subject was "Poliomyelitis."

Dr. Louis J. Novak of Hollywood spoke on heart disease and the attention a patient with the disease should give his health at a meeting of Hollywood Lodge, B'nai B'rith, the first of May.

Dr. Oswald A. Holzer of Melbourne attended the meeting of the International College of Surgeons held the latter part of May at Geneva, Switzerland.

Dr. Sherman R. Kaplan of Miami Beach was principal speaker at a meeting of Hibiscus Lodge 275, F&AM, held the first of May.

Dr. Henry G. Morton of Sarasota addressed a recent meeting of the Rotary Club of that city. His subject was the growth of medical care and hospital facilities in Sarasota.

Dr. Hugh A. Carithers of Jacksonville spoke at a recent meeting of the Duval County Safety Council's P-TA Division. The title of his address

(Continued on page 55)

DRAMAMINE® IN VERTIGO

Notes on the Diagnosis and Management of "Dizziness"

II. False Dizziness



1. Romberg's Sign

The patient stands with his feet together and his eyes closed. Inability to maintain equilibrium may indicate locomotor ataxia or sclerosis of the posterior columns of the spinal cord (tabes dorsalis).

2. Inability to Walk a Straight Line

3. Inability to Stand on One Foot

A patient's inability to stand on one foot without lurching may be a helpful test in distinguishing between "dizziness" which is purely psychogenic and that which is of organic origin.

False dizziness is a sensation of sinking or lightheadedness which is often of psychogenic origin. It should be distinguished from true "dizziness" or vertigo[1] in which there is a definite whirling, moving sensation.

Unsteadiness, lightheadedness and similar manifestations of false dizziness[2] may be psychogenic or the result of arteriosclerosis, hypoglycemia, drug sensitivity and general metabolic disturbances such as anemia and malnutrition. Hypertension is often the cause of these symptoms.

Psychogenic dizziness probably originates at the highest brain centers. It may be described as a sense of uncertainty with occasional mild lurching but not to the point of falling. In these patients there is no nausea, no disturbance of vestibular pathways and otologic and neurologic examinations are negative. The sensation is unaffected by head movement. Symptoms usually disappear[3] with complete rest.

Dramamine® has been found highly effective in many of the conditions already mentioned. Maintenance therapy with Dramamine will often keep the patient from becoming incapacitated by his condition.

Dramamine is also a standard for the management of motion sickness and is useful for relief of nausea and vomiting of fenestration procedures and radiation sickness and for relief of "true dizziness" of other disorders.

Dramamine (brand of dimenhydrinate) is supplied in tablets (50 mg.) and liquid (12.5 mg. in each 4 cc.). G. D. Searle & Co., Research in the Service of Medicine.

1. Swartout, R., III. and Gunther, K.: "Dizziness:" Vertigo and Syncope, GP *8*:35 (Nov.) 1953.

2. DeWeese, D. D.: Symposium: Medical Management of Dizziness. The Importance of Accurate Diagnosis, Tr. Am. Acad. Ophth. *58*:694 (Sept.-Oct.) 1954.

3. Kunkle, E. C.: Central Causes of Vertigo, J. South Carolina M. A. *50*:161 (June) 1954.

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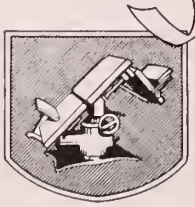
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(Continued from page 52)
was "Accidents Among Florida Children Is Leading Cause of Death."

Dr. Melvin M. Simmons attended the meeting of the American Urological Association held at Los Angeles.

Dr. Samuel Gertman of Miami addressed members of the Dade County Retired Teachers Association at a meeting held the first of May. His subject was "Health Problems of the Elderly."

Dr. Manning J. Rosnick of Miami was principal speaker at a recent meeting of TOPS (Take Off Pounds Sensibly) held at Miami Springs.

Dr. Bernard J. McCloskey of Jacksonville attended meetings of the American College of Allergists held recently at Chicago.

Dr. Robert C. Black of Plant City was honored recently with a party given for him by friends and former patients in the city.

Dr. John M. Gayden of Melbourne has resumed his practice following a year spent at the National Polio Foundation in Warm Springs.

Dr. Samuel W. Root of Jacksonville discussed "The Medical Use of Isotopes" at a recent meeting of the West Riverside Dads' Club of that city.

Dr. Warren J. Brown of Largo was principal speaker at a recent meeting of the Kiwanis Club of Indian Rocks.

Dr. Edgar A. P. Kellerman of West Palm Beach was lead off speaker on a preview observance locally of Mental Health Week which was observed nationally the first week of May.

Dr. Roscoe S. Maxwell of Punta Gorda has been elected president of the Charlotte County Tuberculosis and Health Association.

Dr. David W. Goddard of Daytona Beach attended the meeting of the American Urological Association held at Los Angeles recently.

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more potent
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Meat...

and the Problem of Senile Osteoporosis

Perhaps under the still-persisting influence of the mistaken "health legends" of former days, many older people tend to eat less meat and other nutritionally valuable protein foods than they should; thus, the osteoporosis that occurs naturally in the aging body may be unduly augmented.[1]

A balanced diet supplying optimal amounts of protein is essential, and appears to be useful in preventing and in slowing the progress of osteoporosis in senile persons. Adequate protein intake is instrumental in supporting osteoblastic activity so necessary for production of osseous matrix. "When osteoporosis is present, the prime objective is an adequate, high protein diet (a gram or more [of protein] per kilogram of body weight), to aid in building bony matrix for osteoblastic activity."[1]

Meat constitutes one of the most important sources of protein in the nutrition of the aged. Meat offers biologically effective protein—effective in the maintenance as well as the reconstruction of wasted or damaged tissue. Its natural content of B vitamins and of essential minerals not only helps to supply the daily needs for these nutrients, but is necessary for the proper utilization of amino acids.[2]

The appealing taste of meat, its appetite-stimulating quality, and its almost complete digestibility also are important in geriatric nutrition.

1. Rechtman, A. M., and Yarrow, M. W.: Osteoporosis, Am. Pract. & Digest Treat. 5:691 (Sept.) 1954.

2. Cannon, P. R.; Frazier, L. E., and Hughes, R. H.: Factors Influencing Amino Acid Utilization in Tissue Protein Synthesis, in Symposium on Protein Metabolism, New York, The National Vitamin Foundation, Inc., 1954, pp. 55-90.

The nutritional statements made in this advertisement have been reviewed and found consistent with current medical opinion by the Council on Foods and Nutrition of the American Medical Association.

American Meat Institute

Main Office, Chicago . . . Members Throughout the United States

Drs. John P. Michaels and Alexander P. Maybarduk of Orlando led a discussion on cancer at a meeting held recently in a local theatre there. The meeting was for women only and followed a showing of the film "Breast Cancer."

Dr. James F. Speers of Titusville, Brevard county health officer, discussed the Salk polio vaccine at a recent meeting of the Mims P-TA.

"The Art of Aging" was discussed by four Orlando physicians at the second Sentinel-Star Public Forum held recently in that city. Dr. A. Fred Turner Jr. was principal speaker. Other members of the panel were Dr. Carl D. Hoffmann, Dr. Russell W. Ramsey and Dr. Benjamin Glaser.

Dr. George Lister of Miami discussed the Salk polio vaccine and the immunization program for Dade county at a recent meeting of the Miami Shores Kiwanis Club.

Dr. Irwin S. Leinbach of St. Petersburg addressed a special meeting of the St. Petersburg Minister's Association recently. His subject was "The Doctor and the Minister Working Together in the Healing Processes."

Dr. Emil M. Isberg of Miami Beach, assistant professor of psychiatry at the University of Miami School of Medicine, discussed "Medicine That Melts Anxiety" at the all day Mental Health Fair held the first of May in Miami.

Dr. Melvin Wolkowsky of Miami Beach entered medical service with the U. S. Army on May 27, 1955.

Dr. Nathaniel M. Levin of Miami Beach was principal speaker at the annual meeting of the Florida Laryngectomees Association held recently at Stuart.

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Dr. George T. Harrell Jr., dean of the College of Medicine of the University of Florida, and Dr. David M. Davis of St. Petersburg were among a group of speakers who appeared on the program for the annual spring meeting of the Florida Division of the American Society of Medical Technologists held recently at St. Petersburg.

Dr. Fred H. Albee Jr. of Daytona Beach was principal speaker at the recent annual meeting of the Florida Chapter of the American Physical Therapy Association held at Daytona Beach.

Dr. George T. Harrell Jr., dean of the College of Medicine of the University of Florida, and Dr. James R. Cook of Orlando were included on the program for the all day meeting sponsored the first of May by the Orange County Medical Society.

Dr. O. F. Green of Mayo was honored May 26 when citizens of the area set aside a special day for him. On the program was an old-fashioned basket picnic and a parade by the high school band.

Appreciation Day for Dr. Edwin C. Hanson of Belleview was held late in April. The affair, sponsored by the Chamber of Commerce, honored Dr. Hanson for 20 years service in the area. On the program were Dr. Richard C. Cumming of Ocala, mayor of that city; Dr. William H. Turnley of Ocala, president of the Marion County Medical Society, and Dr. Thomas H. Wallis, also of Ocala.

In addition to a plaque, Dr. Hanson was presented a watch bought with funds contributed by the people he has served.

Dr. Shaler Richardson of Jacksonville, editor of The Journal of the Florida Medical Association, attended the meeting of the American Ophthalmological Society held June 2-4 at White Sulphur Springs, Va.

Several outstanding speakers are on the program for the annual meeting of the Florida Academy of General Practice being held October 22-23 at Daytona Beach, Dr. Ruth T. Rogers of Daytona Beach, publicity chairman for the meeting, has announced.

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Among the speakers are Dr. T. E. Bailey of the Medical College of Georgia; Dr. Richard Brassfield, Pack Medical Group, Memorial Cancer Center, New York City; Dr. William F. Braasch, emeritus staff member of Mayo Clinic, Rochester, Minn., and Dr. William W. Schildecker of Daytona Beach, who will be presiding officer for a clinical-pathological conference.

Dr. Rogers stated that the entire program for the meeting had not been completed.

Dr. Edward R. Annis of Miami was the guest speaker at the eleventh annual birthday luncheon commemorating the founding of the Duval County Visiting Nurses Association held at the Roosevelt Hotel in Jacksonville on May 19. The subject of his address was "Let's Live a Little Longer."

The program for the 104th annual meeting of the American Medical Association held June 6-10 at Atlantic City listed numerous members of the Florida Medical Association as being active on the scientific program and in the other activities.

Serving in the House of Delegates were Drs. Reuben B. Chrisman Jr. of Miami; Louis M. Orr of Orlando, and Francis T. Holland of Tallahassee. Dr. Homer L. Pearson Jr. of Miami presided as chairman of the Judicial Council of the American Medical Association.

Dr. Ralph S. Sappenfield of Miami served as chairman of the Section on Anesthesiology and Dr. Richard A. Mills of St. Petersburg was a member of the executive committee of the Section on General Practice.

In addition to Dr. Sappenfield, scientific papers were presented by Drs. Robert J. Needles of Fort Lauderdale; Maurice Lev; Paul N. Unger, and Donald F. Marion of Miami. Discussions were opened by Drs. W. A. D. Anderson; Philipp R. Rezek, and Gerard Raap of Miami.

Other physicians who participated in conferences, scientific exhibits and demonstrations included Drs. George F. Schmitt; Benjamin G. Oren, and Herbert W. Virgin Jr. of Miami, and Dr. Wray J. Tomlinson of Jacksonville.

Dr. Samuel E. Kaplan of Venice was principal speaker at a meeting of the Rotary Club there the latter part of June. He discussed the recently developed Salk polio vaccine.

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Dr. Theodore Norley of West Palm Beach entered medical service with the U. S. Army on April 5, 1955.

Drs. Jack H. Bowen, Joseph A. Farrington and Lauren M. Sompayrac of Jacksonville attended the meetings of the Southeastern Dermatological Association held in Memphis recently. Dr. Sompayrac was elected President of the Association for the coming year.

Drs. James L. Borland, Leonard Garten, Karl B. Hanson, Tyndall P. Harris, Nathaniel Jones, Joseph J. Lowenthal and Mason Romaine III attended the annual meeting of the American College of Physicians held recently in Philadelphia.

Dr. John F. Lovejoy of Jacksonville attended the meeting of the International College of Surgeons held in Geneva, Switzerland.

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Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

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COMPONENT SOCIETY NOTES

Broward

The regular monthly meeting of the Broward County Medical Association was held May 24 in the health department building at Fort Lauderdale.

Dade

Dr. Howard A. Engle of Miami was the principal speaker for the regular monthly meeting of the Dade County Medical Association held June 7. His subject was "The Brain-Damaged Child."

Duval

The regular monthly meeting of the Duval County Medical Society was held June 7 in Sellers Auditorium at Jacksonville. A feature of the program was a symposium on infertility. Principal speakers were Drs. Joseph H. St. John, William A. Van Nortwick, Donald M. Baldwin and J. Champneys Taylor.

Hillsborough

The regular monthly meeting of the Hillsborough County Medical Association was held June 7 at Tampa. The program was a public affairs forum on the subject "What's Needed in Tampa's Public Hospitals?"

Marion

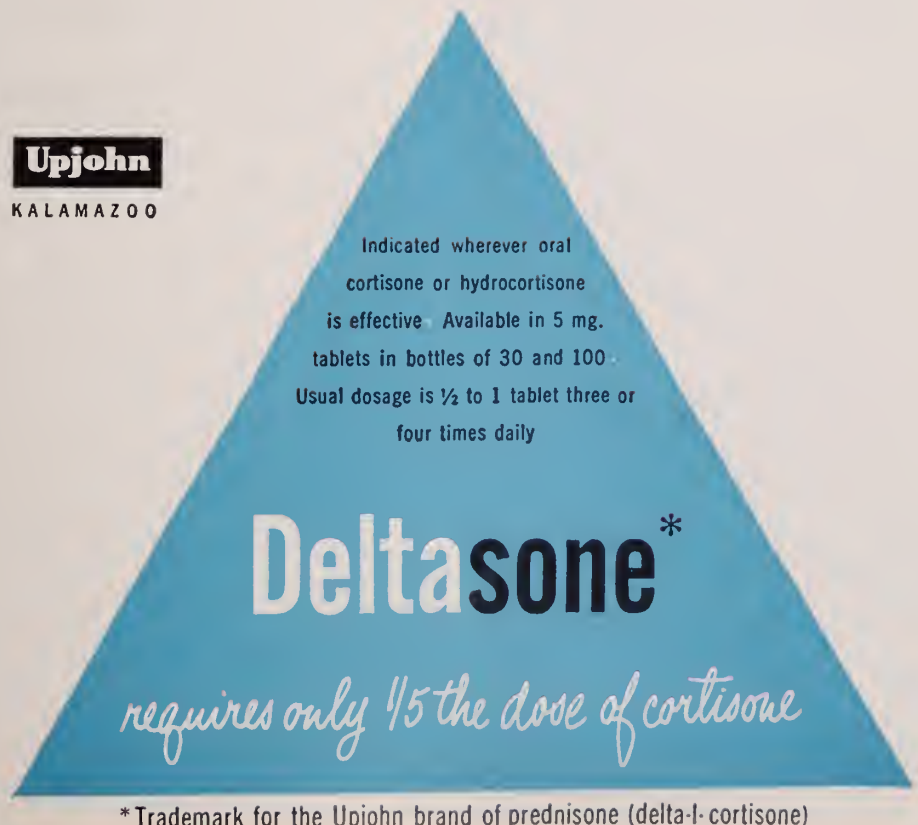
At the regular monthly meeting of the Marion County Medical Society on May 17, Dr. James L. Strange of McIntosh was appointed to represent the Society at the Twenty-Third Annual Graduate Short Course for doctors of medicine being held at Jacksonville June 20-24. Dr. Strange has attended each of the courses since they were begun.

Members of the Woman's Auxiliary met with the Society at the home of Dr. and Mrs. Robert E. Thompson.

St. Johns

Official note of the valuable community service of members of the St. Johns County Medical Society has been taken by the Board of County Commissioners of St. Johns County.

In a resolution adopted by the commissioners at a meeting in May, recognition is given to members of the Society for "freely and unselfishly giving their time and skill" in the immunization of the school children of the county. Further recognition is accorded members for "performing without compensation professional services for indigents."



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Florida Growth Continues

The phenominal growth in population in Florida since World War II is reflected in the number of new doctors who have come into our state and a resulting growth in the size of the Woman's Auxiliary to the Florida Medical Association.

The past year has shown the greatest growth we have ever had and we are proud of the increase in our membership. To us, this signifies that Auxiliary projects are appealing and of worth to the doctors' wives in our state, and that the doctors' families are seeking friendship and understanding one from the other.

In October, 1954, the Woman's Auxiliary to the Manatee County Medical Society was organized with 26 members. On May 10, Mrs. Edward W. Cullipher, First Vice President of the Woman's Auxiliary to the Florida Medical Association, assisted by Mrs. Scottie J. Wilson, President-elect, and Mrs. Richard F. Stover, immediate past president, organized the Woman's Auxiliary to the St. Lucie-Okeechobee-Martin County Medical Society. There are 13 charter members of this new

Auxiliary. Mrs. Laurance D. Van Tilborg was elected the first president, Mrs. Henry E. Branca, vice president, and Mrs. John D. Browning, secretary-treasurer. Mrs. Van Tilborg has appointed her committee chairmen for the year and the first meeting after further organization will be in October, 1955.

The Woman's Auxiliary to the Florida Medical Association now has 23 organized auxiliaries and approval for another auxiliary made up of wives of members of three medical societies. The membership dues paid for the year reflect increases in all but four auxiliaries, three of these having lost from one to three members and one remaining at the level of last year.

The largest increase was realized in Duval county where membership jumped from 171 to 220 members. Next largest increase was in Dade county which increased from 350 to 386 members. Provisional members who will be eligible for full membership in the year to come are not counted in these figures.

By districts the membership is now as follows:

District A, 165 members, 156 in organized auxiliaries and 9 members-at-large.
District B, 547 members, 542 in organized auxiliaries and 5 members-at-large.
District C, 420 members, 412 in organized auxiliaries and 8 members-at-large.
District D, 599 members, 576 in organized auxiliaries and 23 members-at-large.

At the state level last year, membership was 1,455 and at the end of this year, we had 1,731 members, an increase of 276 or 18.9 per cent. The Woman's Auxiliary to the American Medical Association had asked each state for a ten per cent increase, so in membership as in practically every phase of auxiliary work, the 1954-55 year shows almost double the work asked of us.

With the increased enthusiasm in the auxiliaries we already have organized, and with the increasing requests we are getting from doctors' wives in our unorganized areas, everything indicates that our amazing increase will continue.

The organization committee of the state auxiliary is composed of the four vice presidents, one vice president being elected from each medical district in the state. For 1955-56, Mrs. Edward W. Cullipher, Dade county, is first vice president and chairman of the organization committee. She will be assisted by Mrs. Sidney G. Kennedy Jr.,

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Bumbalo, T. S., Gustina, F. J., and Oleksiak, R. E.:
J. Pediat. 44:386, 1954.

White, R. H. R., and Standen, O. D.:
Brit. M. J. 2:755, 1953.

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Brown, H. W.:
J. Pediat. 45:419, 1954.

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District A; Mrs. John D. Bloom, District B, and Mrs. William A. Hodges Jr., District C.

In District A there are seven unorganized areas, three of which are in the process of being organized now. District B has two unorganized counties, one of which may join with one of our already organized auxiliaries. District C has two unorganized areas with promise of organization in the near future for one of these and District D has two, one of which it is hoped may be organized during the coming year.

There is a definite place for the member-at-large in the state auxiliary and it is hoped that in those counties that do not have organizations, every doctor's wife will send her dues of $2.75 and become a member-at-large of the Woman's Auxiliary to the Florida Medical Association.

Mrs. Richard F. Stover

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Anderson, William A. D., Miami
Byrne, James B., Coral Gables
Crandall, Clarence R., Eau Gallie
Crissey, Raymond T., Homestead
Doty, James R., Rockledge
Ellis, Donald S., Palm Beach
Feigenbaum, David, Miami
Goodman, James J., Miami
Gottsch, John E., Tampa
Hollomon, John J. Jr., Panama City
Kinney, Edward L., Coral Gables
Mangone, Edith K., Melbourne
Martini, Taverno A., Tampa
Orr, Alva D., Fort Pierce
Rudnick, Joseph H., Coral Gables
Silver, Marvin, Bradenton
Sweimler, Myrtle, Seffner
Watson, Robert M., Miami
Weres, James, Williston
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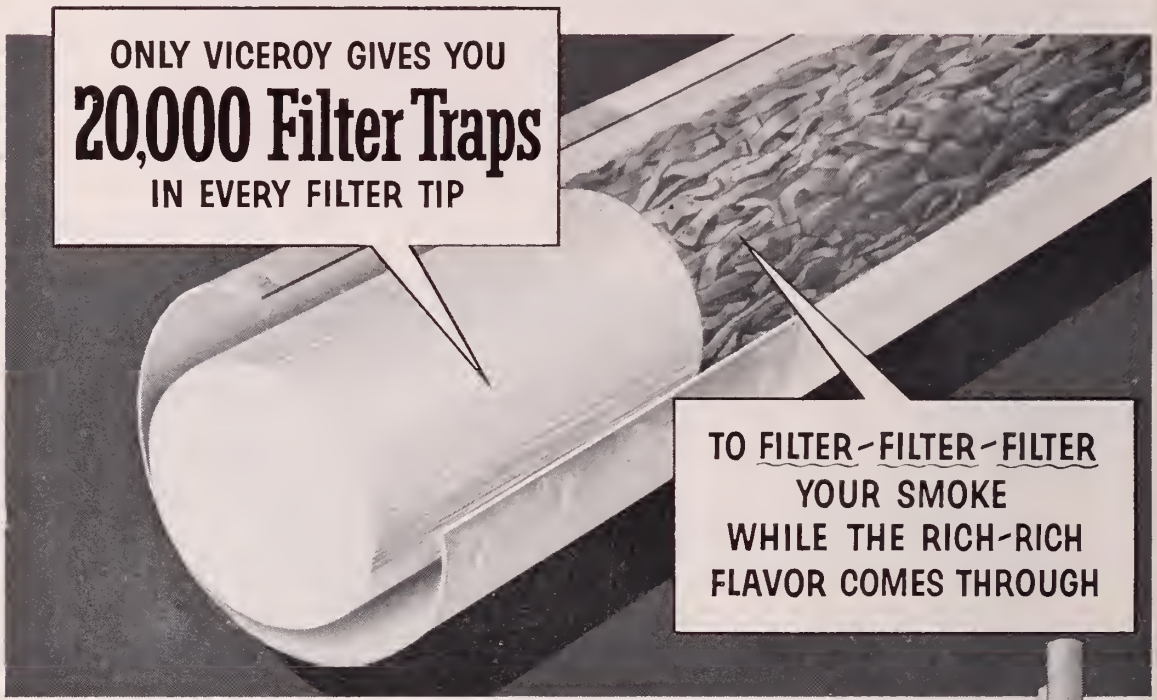
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Brand of oxytetracycline hydrochloride HCl

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- Rapidly attained therapeutic levels
- Proved broad-spectrum action
- For use when oral therapy is not practical or is contraindicated
- Just 100 mg. (one single-dose vial) every 8 to 12 hours is adequate for most infections in adults
- Usually well tolerated on DEEP intramuscular injection *(Contains procaine to minimize local tissue reaction)*
- When reconstituted, forms a *clear* solution

Supplied: In dry powder form, in single-dose vials. When reconstituted by addition of 2.1 cc. of sterile aqueous diluent, each single dose (2 cc.) contains:

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Magnesium chloride	5%
Procaine hydrochloride	2%

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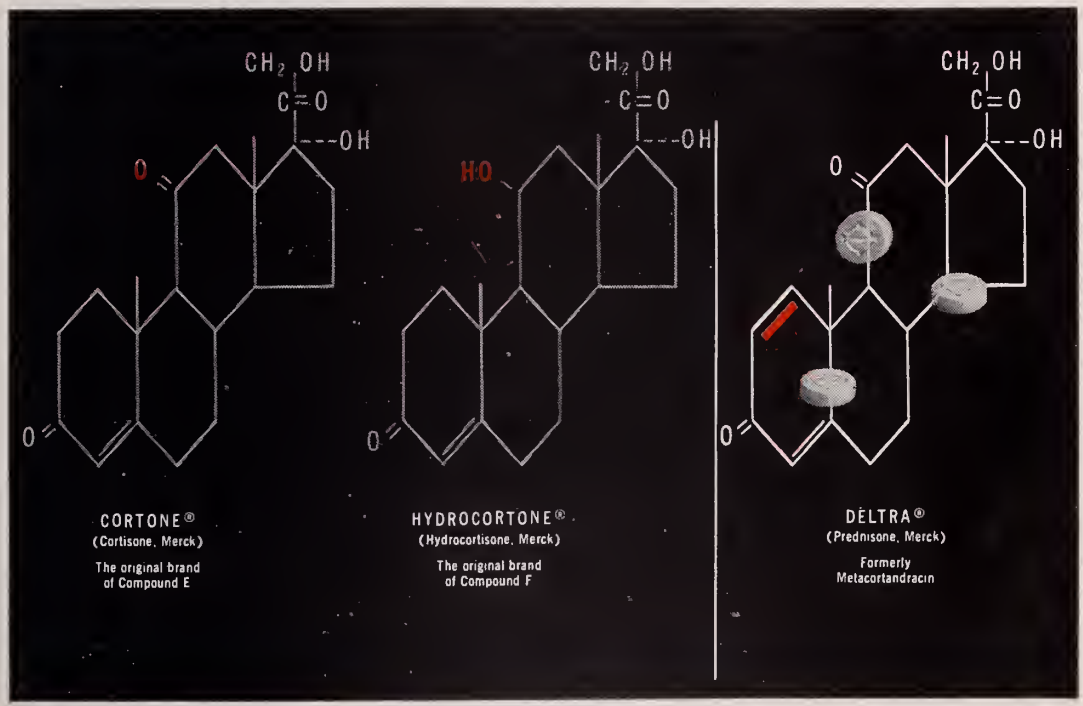
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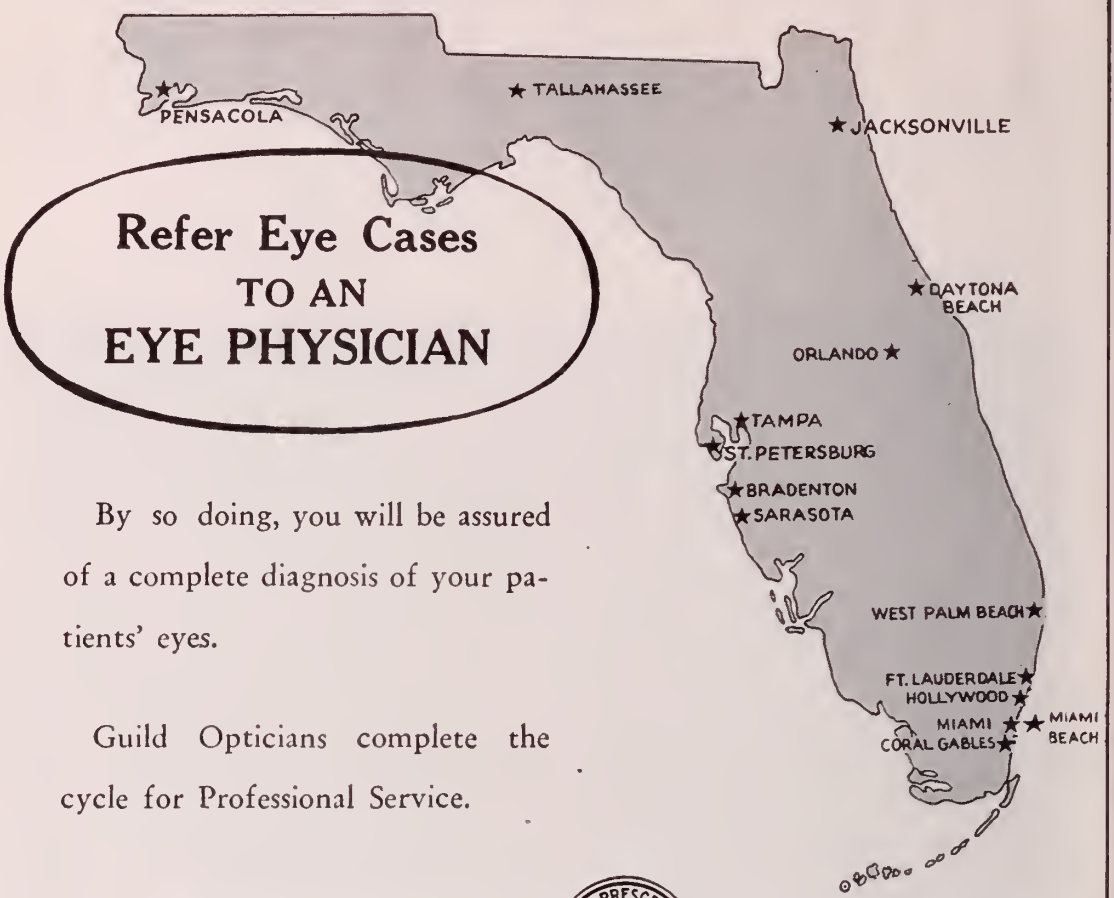
Salt and water retention are less likely with recommended doses of DELTRA than with the higher doses of cortisone required for comparable therapeutic effect.

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	T. S. Budd	122 S. E. First St.
	Harry H. Marsh	401 Langford Bldg.
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St. Petersburg	K. M. Dowdy	322 Central Ave.
Daytona Beach	Harvey E. White	220 S. Beach St.
Pensacola	Bennie Barberi	18 W. Garden St.
Fort Lauderdale	Ray Goodwill	22 E. Las Olas Blvd.
Fort Pierce	William Franklin	196 N. 4th St.
Tallahassee	Alice K. Jackson	105 College Ave.
Sarasota	Oscar Loewe	Main St.
Bradenton	James T. Lynn, Jr.	1021 Manatee Ave., W.
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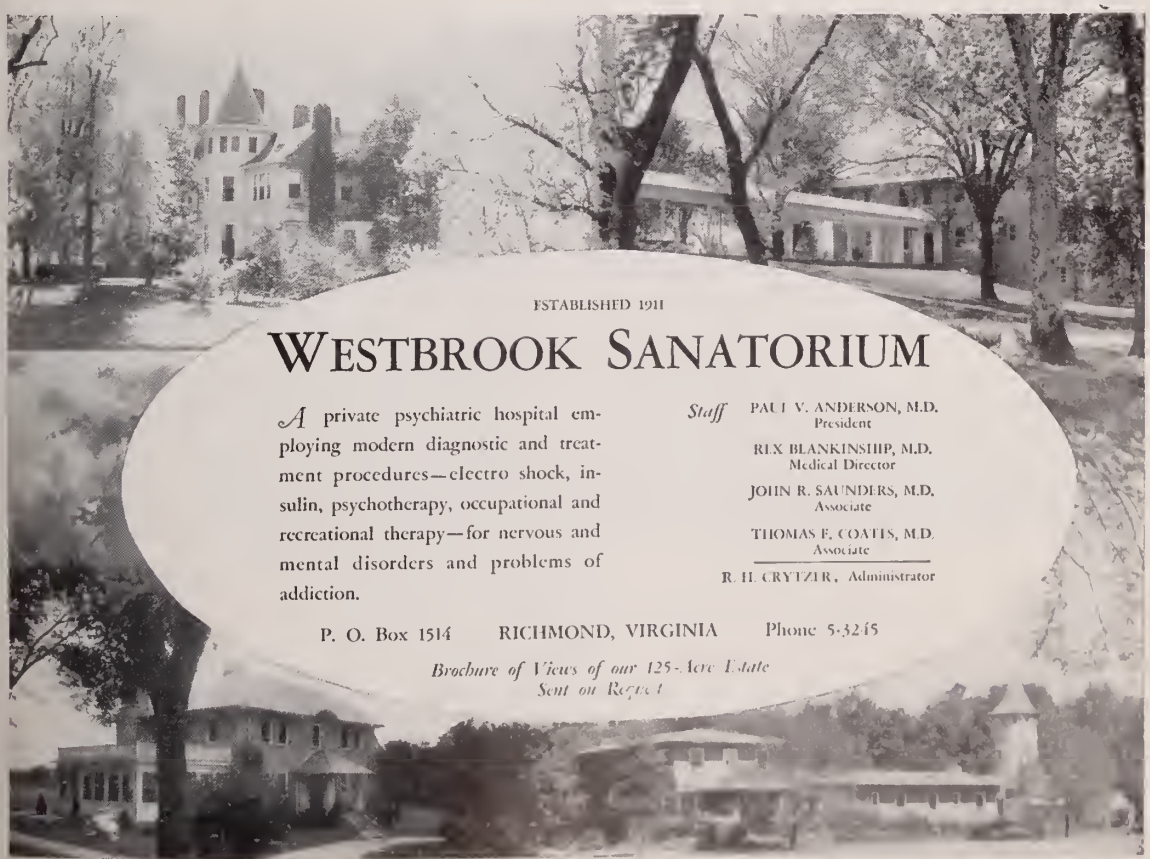
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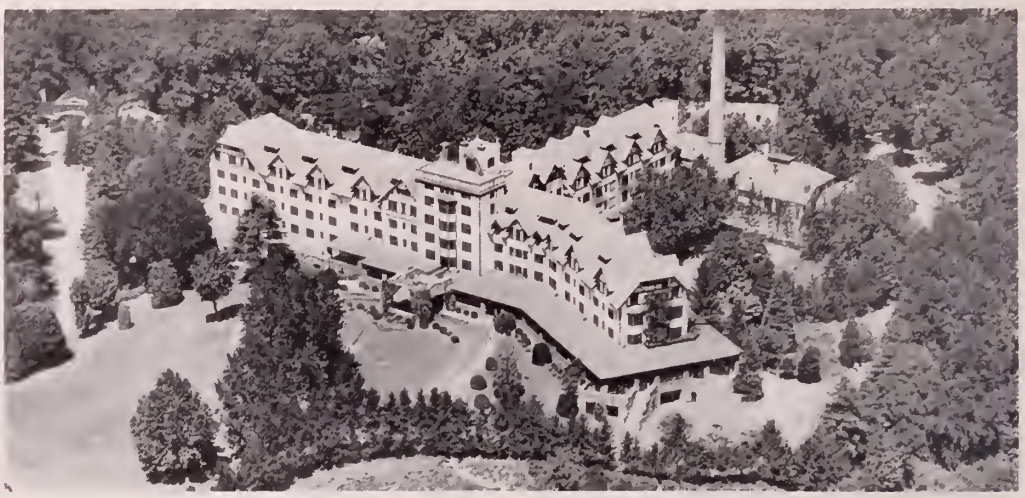
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ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
la Medical Association	John D. Milton, Miami	Samuel M. Day, Jacksonville	Miami Beach, May 13-16, '56
la Medical Districts	Ralph W. Jack, Miami	Council Chairman	
Northwest	William P. Hixon, Pensacola	Walter J. Baker, Foley	Pensacola, Oct. '55
Northeast	Henry J. Babers Jr., Gainesville	Charles L. Park Sr., Sanford	Gainesville, Oct. '55
Southwest	C. Frank Chunn, Tampa	James R. Boulware Jr., Lakeland	Lakeland, Oct. '55
Southeast	James R. Sory, West Palm Beach	Ralph S. Sappenfield, Miami	Fort Lauderdale, Oct. '55
da Specialty Societies			
emy of General Practice	Frank T. Linz, Tampa	James B. Hodge Jr., Tampa	Daytona Beach, Oct. 22-23, '55
gy Society	W. Ambrose McGee, W. P. Bch.	Norris M. Beasley, Ft. Lauderdale	
nthesiologists, Soc. of	Wayland T. Coppedge Jr., Jax	William H. Houston, Jacksonville	
t Phys., Am. Coll., Fla. Chap.	Hawley H. Seiler, Tampa	William L. Potts, Lantana	
n. and Syph., Assn. of	Joseph L. Hundley, Orlando	Kenneth J. Weiler, St. Petersburg	
th Officers' Society	Clarence L. Brumback, W. P. Bch.	Lorenzo L. Parks, Jacksonville	
strial and Railway Surgeons	Frank L. Fort, Jacksonville	John H. Mitchell, Jacksonville	
ology & Psychiatry	Edward H. Williams, Miami	J. Robert Campbell, Tampa	
and Gynec. Society	J. Champneys Taylor, J'sonville	Reuben B. Chrisman Jr., Miami	
hal. & Otol., Soc. of	Charles W. Boyd, Jacksonville	Kenneth S. Whitmer, Miami	
opedic Society	Edward W. Cullipher, Miami	Robert P. Keiser, Coral Gables	
ologists, Society of	Millard B. White, Sarasota	Wray D. Storey, Tampa	
atric Society	Lewis T. Corum, Tampa	Joel V. McCall Jr., Daytona Beach	Ft. Lauderdale, Nov. 3-5, '55
tologic Society	Thomas F. Nelson, Tampa	George Williams Jr., Miami	
ological Society	Hugh G. Reaves, Sarasota	Donald H. Gahagen, Ft. Lauderdale	
eons, Am. Coll., Fla. Chapter	Joseph S. Stewart, Miami	C. Frank Chunn, Tampa	
ogical Society	David W. Goddard, Daytona Bch.	W. Dotson Wells, Fort Lauderdale	
ida—			
sic Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, Nov. 5, '55
ood Banks, Association	John T. Stage, Jacksonville	John B. Ross, Jacksonville	St. Petersburg, 1955
ue Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	St. Petersburg, Dec. 6, '55
ue Shield of Florida, Inc.	Russell B. Carson, Ft. Lauderdale	John T. Stage, Jacksonville	
ncer Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	Miami Beach, May 13, '56
inical Diabetes Assn.	Sidney Davidson, Lake Worth	Edward R. Smith, Jacksonville	Daytona Beach, Oct. 20-21, '55
ental Society, State	T. A. Price, D.D.S., Miami	W. A. Buhner, D.D.S., Daytona Bch.	Miami Beach, May 9-11, '56
eart Association	Victor H. Kugel, Miami Beach	Edwin P. Preston, Miami	Miami, May, '55
ospital Association	Mr. Pat N. Groner, Pensacola	Mr. Steve F. McCrimmon, C. Gbls.	St. Petersburg, Nov. 16-18, '55
edical Examining Board	Frank D. Gray, Orlando	Homer L. Pearson Jr., Miami	
edical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
urse Anesthetists, Fla. Assn.	Miss Dorothy Jackson, C. Gables	Mrs. Lulla F. Bryan, Miami	St. Petersburg, Dec. 6-8, '55
urses Association, State	Martha Wolfe R.N., Coral Gables	Agnes Anderson, R.N., Orlando	Daytona Beach, Nov. 28-30, '55
harmaceutical Assoc., State	Miss Frances Walpole, Sarasota	Mr. R. Q. Richards, Ft. Myers	
ublic Health Association	Mr. J. A. Mulrennan, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Daytona Beach, Oct. 20-22, '55
rudeau Society	Harold W. Johnston, Orlando	Howard M. DuBose, Lakeland	
uberculosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mr. Ernest L. Abel, W. Palm Beach	
oman's Auxiliary	Mrs. Samuel Lombardo, J'sonville	Mrs. Leffie M. Carlton Jr., Tampa	Miami Beach, May 13-16, '56
erican Medical Association	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Chicago, June 11-15, '56
.M.A. Clinical Session	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Boston, Nov. 29-Dec. 2, '55
thern Medical Association	Robt. L. Sanders, Memphis, Tenn.	Mr. V. O. Foster, Birmingham	Houston, Nov. 14-17, '55
ama Medical Association	F. L. Chenault, Decatur	Douglas L. Cannon, Montgomery	Birmingham, Apr. 19-21, '56
rgia, Medical Assn. of	H. Dawson Allen Jr., Milledgeville	David Henry Poer, Atlanta	Atlanta, May 13-16, '56
. Hospital Conference	Mr. D. O. McClusky Jr. Tuscaloosa, Ala.	Mr. Pat Groner, Pensacola	Miami Beach, Apr. 18-20, '56
theastern Allergy Assn.	Ben Miller, Columbia, S. C.	Kath. B. MacInnis, Columbia, S.C.	Charlotte, N. C., Oct. '56
theastern, Am. Urological Assn.	Sidney Smith, Raleigh, N. C.	Robert F. Sharp, New Orleans	Hollywood, Mar. 25-29, '56
theastern Surgical Congress	Donald S. Daniel, Richmond	B. T. Beasley, Atlanta	Richmond, Mar. 12-15, '56
f Coast Clinical Society	Walter C. Payne Sr., Pensacola	Barkley Beidleman, Pensacola	Pensacola, Oct. 27-28, '55

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SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Total Members
Alachua	Edwin H. Andrews, Gainesville	Henry S. Blank, Gainesville	2nd Tues.	57
**Bradford, Gilchrist, Union*				
Bay	William F. Humphreys Jr., Panama City	Roderick C. Webb, Panama City	1st Tues.	28
Brevard	Lee Rogers Jr., Cocoa	Charles E. Russell, Cocoa	2nd Tues.	37
Broward	Ernest E. Serrano, Hollywood	Alfred E. Cronkite, Fort Lauderdale	4th Tues.	121
Columbia	Robert B. Harkness, Lake City	Thomas H. Bates, Lake City	1st Mon.	11
**Baker, Hamilton*				
Dade	L. Washington Dowlen, Miami	Robert F. Dickey, Miami	1st Tues	724
De-Soto-Hardee-Highlands-Glades	Gordon H. McSwain, Arcadia	Harold S. Agnew, Arcadia	1st Tues.	28
Duval	Raymond H. King, Jacksonville	Eugene M. Frame, Jacksonville	1st Tues.	300
**Clay*				
Escambia	George W. Morse, Pensacola	Paul F. Baranco, Pensacola	2nd Tues.	107
**Santa Rosa*				
Franklin-Gulf	Warren T. Weathington, Apalachicola	Joseph P. Hendrix, Port St. Joe	Last Wed.	6
Hillsborough	Frank S. Adamo, Tampa	Julien C. Pate Jr., Tampa	1st Tues.	189
Indian River	Kip G. Kelso, Vero Beach	Vernon L. Fromang, Vero Beach	2nd Tues.	10
Jackson-Calhoun	Henry I. Langston, Marianna	Francis M. Watson, Marianna	Quarterly	17
Lake	Louis R. Bowen, Eustis	J. Basil Hall, Tavares	1st Wed.	29
**Sumter*				
Lee-Charlotte-Collier-Hendry	Baker Whisnant, Fort Myers	James L. Bradley, Fort Myers	3rd Mon.	38
Leon-Gadsden-Liberty-Wakulla-Jefferson	William L. Hunter, Monticello	Odis G. Kendrick Jr., Tallahassee	Quarterly	67
Madison	A. Franklin Harrison, Madison	Wallace E. Winter, Madison		6
Manatee	Marjorie L. Warner, Bradenton	Harvey C. Pauley Jr., Bradenton	2nd Tues.	31
Marion	William H. Turnley, Ocala	Bertrand F. Drake, Dunnellon	3rd Tues.	30
**Levy*				14
Monroe	Ralph Herz, Key West	William R. Ploss, Key West	1st Thurs.	
Nassau	David G. Humphreys, Fernandina Beach	John W. McClane, Fernandina Beach	Last Fri.	11
Orange	Don C. Robertson, Orlando	Walter A. Derrick, Orlando	3rd Wed.	193
**Osceola*				
Palm Beach	Edwin W. Brown, West Palm Beach	James R. Anderson, West Palm Beach	4th Mon.	141
Pasco-Hernando-Citrus	Harry G. Brownlee, Zephyrhills	W. Wardlaw Jones, Dade City	2nd Thurs	16
Pinellas	Clyde O. Anderson, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	226
Polk	Samuel J. Clark, Lakeland	Marion W. Hester, Lakeland	2nd Wed.	101
Putnam	Grover C. Collins, Palatka	Alfred P. Peretti, Palatka	2nd Tues.	10
St. Johns	George C. Hopkins, St. Augustine	Reuben J. Plant Jr., St. Augustine	3rd Tues.	21
St. Lucie-Okeechobee-Martin	Henry E. Branca, Fort Pierce	Adrian M. Sample, Fort Pierce	3rd Thurs.	23
Sarasota	Melvin M. Simmons, Sarasota	Andrew J. Jesacher, Sarasota	2nd Tues.	58
Seminole	John M. Morgan, Sanford	Terry Bird, Sanford	2nd Tues.	20
Suwannee	William P. Blackmon, Mayo	Hiram B. Curry, Jasper	1st Sat.	10
Taylor	John H. Parker Jr., Perry	Ralph J. Greene, Perry	Last Fri.	5
**Dixie, Lafayette*				
Volusia	Robert L. Miller, Daytona Beach	Achille A. Monaco, Daytona Beach	2nd Tues.	85
**Flagler*				
Walton-Okaloosa	Richard H. Lee, Crestview	Frederic E. Caldwell, Fort Walton Beach	3rd Tues	20
Washington-Holmes	L. H. Paul, Bonifay	Bayllye W. Dalton, Chipley		5

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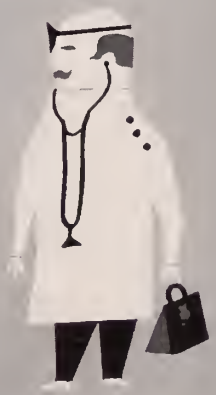
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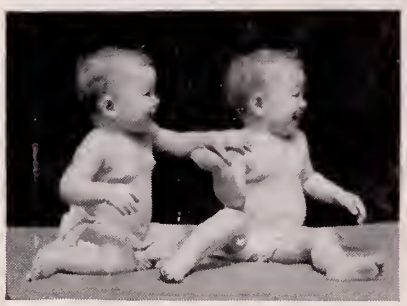
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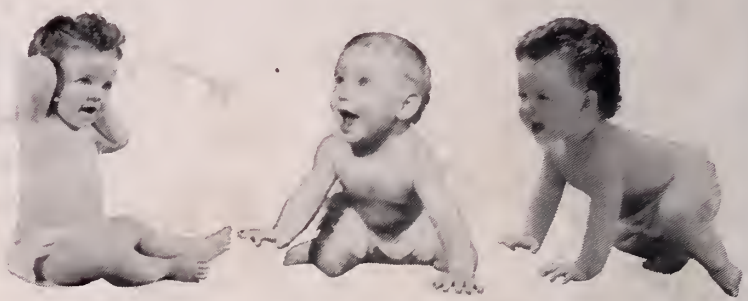


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(1) Jeans, P. C., in A. M. A. Handbook of Nutrition, ed. 2, Philadelphia, Blakiston, 1951, pp. 275-278.

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The Journal OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XLII AUGUST, 1955 No. 2

MEDICAL DISTRICT MEETINGS
OCTOBER 10-14, 1955

IN THIS ISSUE

Carcinoma of the Stomach
Alton Ochsner and John Blalock

Acute Abdominal Disease
Sidney G. Kennedy Jr.

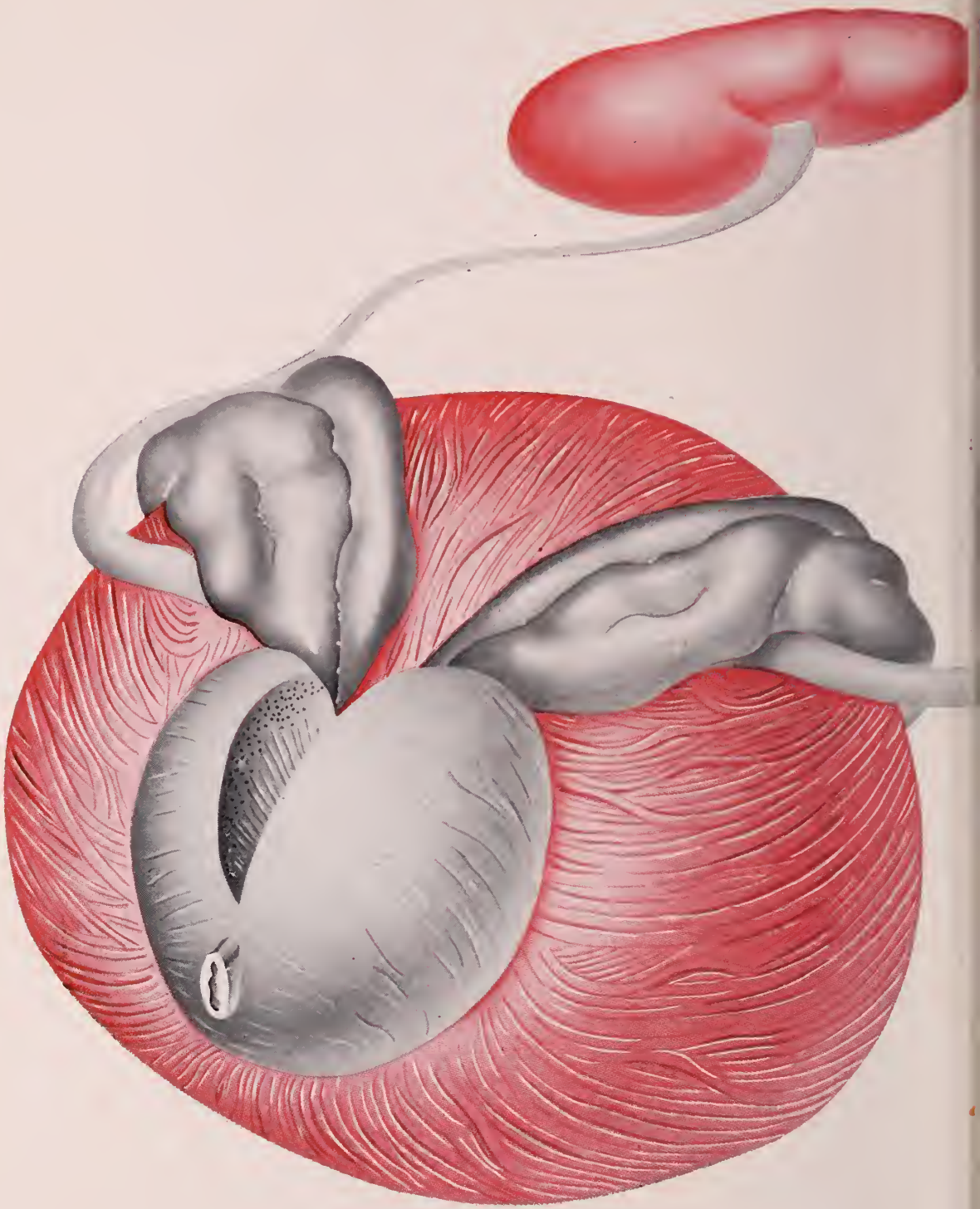
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Gretchen E. Collins, Ed. M.

Treatment of Trigeminal Neuralgia
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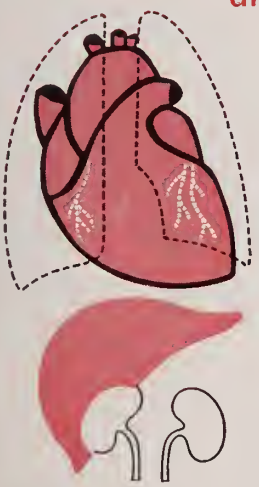
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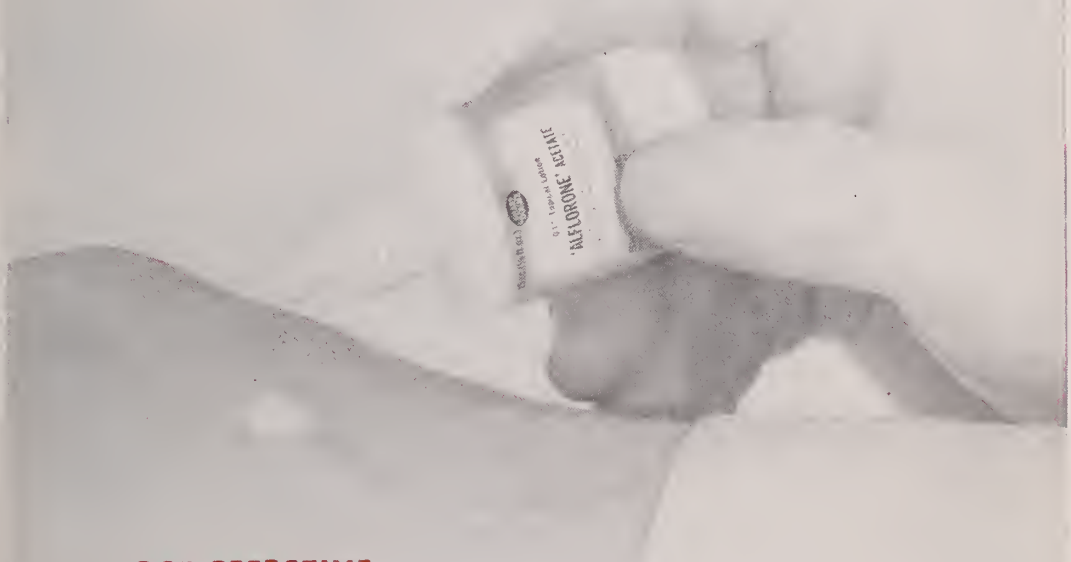
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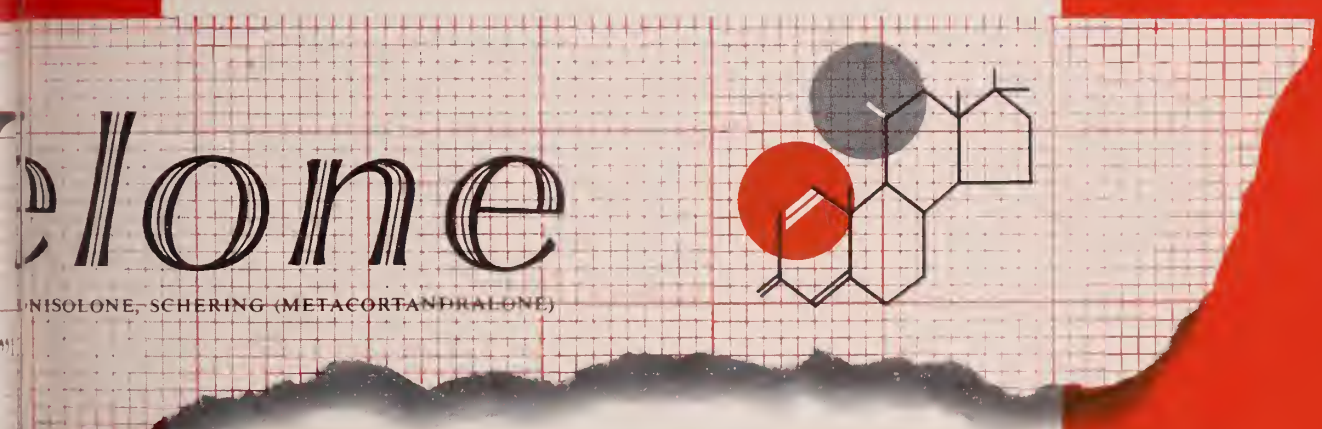
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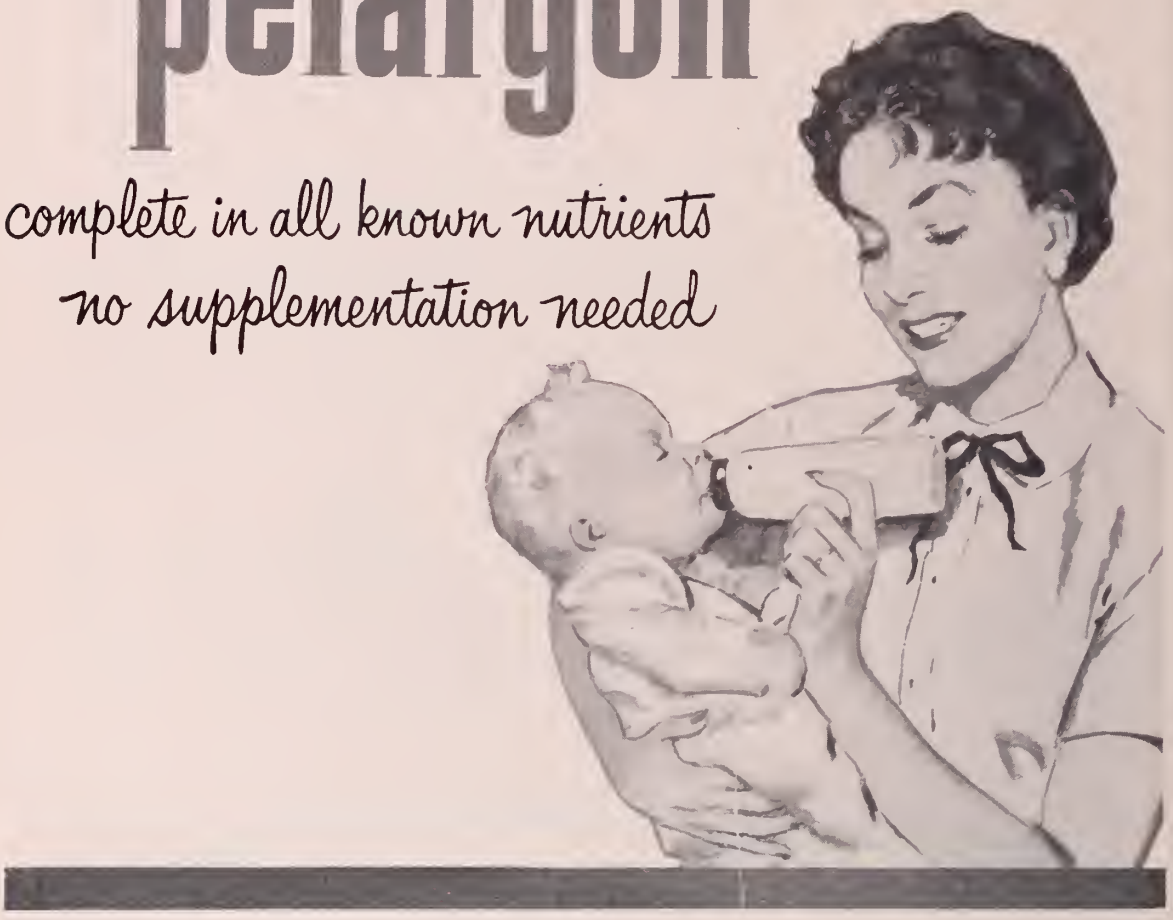
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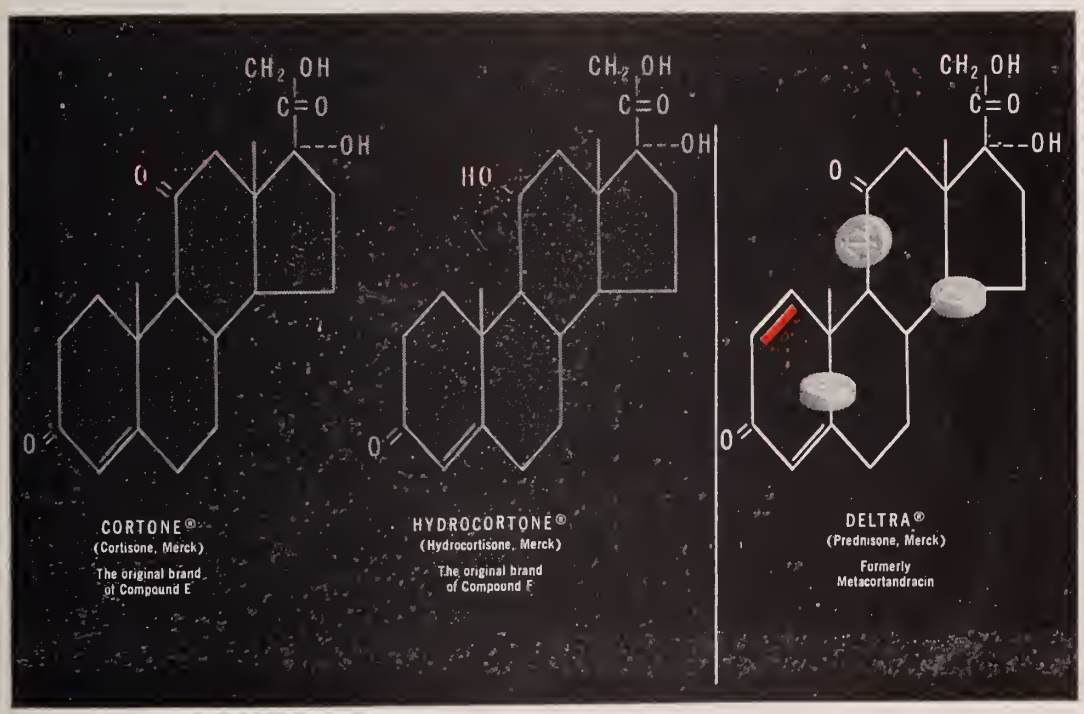
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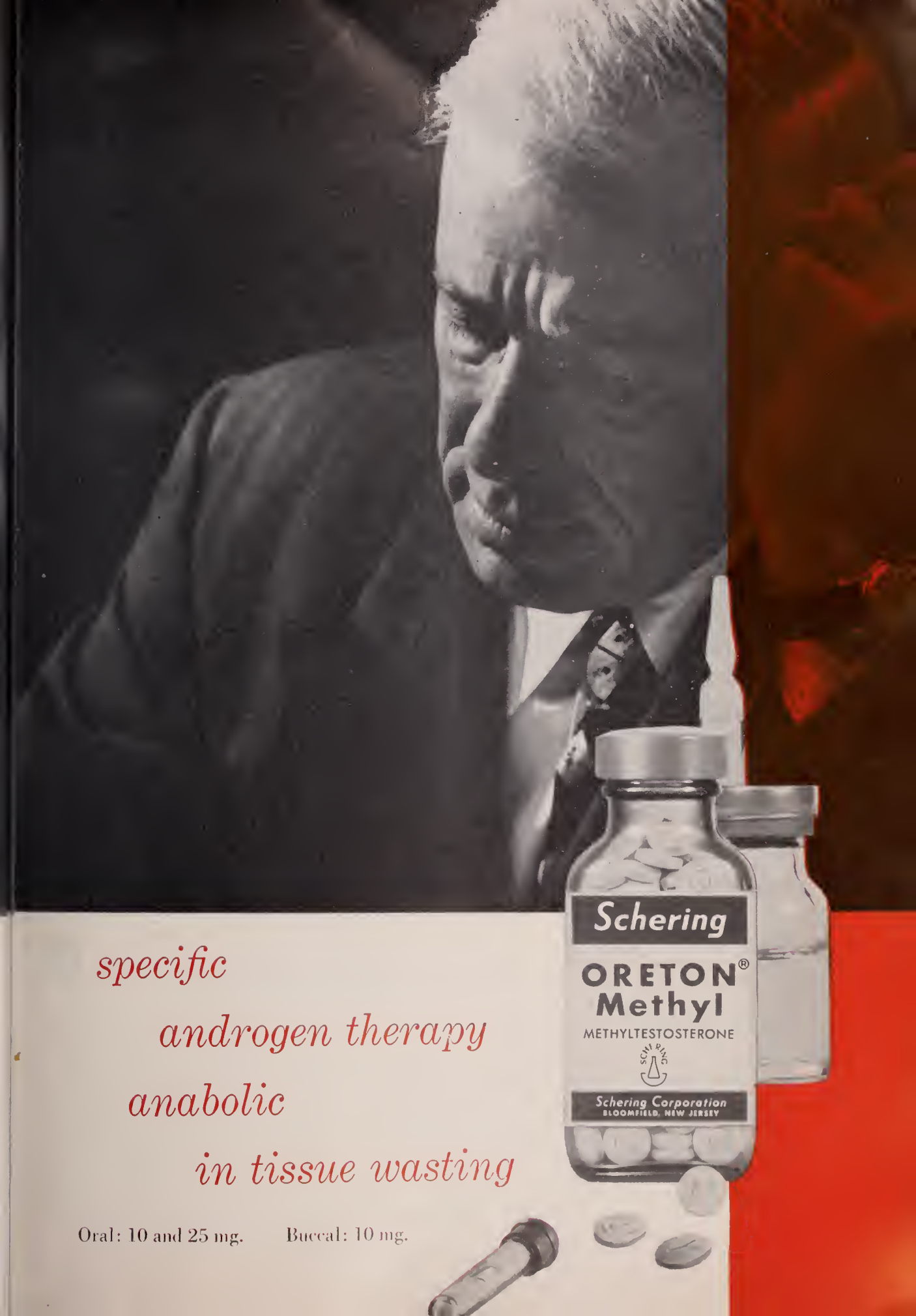
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Carcinoma of the Stomach
Need for Earlier Diagnosis and More Adequate Therapy

ALTON OCHSNER, M.D.
AND
JOHN BLALOCK, M.D.
NEW ORLEANS

Since medical records have been available, cancer of the stomach has been one of the most frequent cancers in men. In fact, it exceeded all other cancers until recently when it was superseded in frequency by cancer of the lung. At the present time cancer of the stomach represents 18 per cent of all cancers, and approximately 40,000 people die annually in the United States from cancer of the stomach.[1] In 1948, there were 17.9 deaths from cancer of the stomach per 100,000 population, and in 1953 this rate had increased to 53.7 deaths. Lawton, Fildes and Seidman,[2] in a series of 170,962 patients admitted to the Hines Hospital, found that 0.6 per cent of all patients admitted and 4.7 per cent of all cancer patients had cancer of the stomach. Berkson, Walters, Gray and Priestley[3] stated that one in every 200 patients admitted to the Mayo Clinic has a malignant lesion of the stomach.

For some unexplained reason, the incidence of gastric cancer is apparently lower in the South than in the North except in Negroes. From 1941 to 1951, inclusive, 587,356 patients were admitted to the Charity Hospital in New Orleans, of whom 2,211 had gastric carcinoma, an incidence of 0.1376 per cent, or one in every 265 admissions.[4] The incidence in white patients was one in 279 and in Negroes, one in 258 admissions. If the obstetric patients are excluded, these figures are one in 277 in white patients and one in 197 in Negroes. In New Orleans in 1947, the number of cases of gastric cancer per 100,000 population was 23.5 for white persons and 36.6 for Negroes.[5] For the same year, the incidences for both white and nonwhite persons in San Francisco and Alameda counties and in Denver were 30.6 and 26.9, respectively. In the Ochsner Clinic, the incidence of gastric malignant lesions among all patients was one in every 555, and one in every 588 had gastric carcinoma. Cancer of the stomach is apparently increasing in other countries as well. Blomquist[6] stated that the incidence of cases of gastric cancer as compared with total cases in Helingfors, Finland increased in the period 1926 to 1945 from 0.5 per cent to 1.2 per cent in the period 1950 to 1952.

In spite of the fact that cancer of the stomach has been and still is a common lesion in men, the results from its treatment are bad. Far too frequently by the time a diagnosis is made, the lesion is not amenable to curative therapy and only palliation is possible. The five year survival rates in all patients admitted to the better institutions in the United States are extremely low, ranging from about 5 per cent according to Lawton and his associates;[2] Clark,[7] 5 per cent; State, Moore and Wangensteen,[8] 6.6 per cent; Welch and Allen,[9] 7 per cent; Safar and Cliffton,[10] 8.8 per cent; Moore and Morton,[11] 11.7 per cent, to 14 per cent according to Berkson and his co-workers.[3] In our series, there was a five year survival rate of 7.2 per cent.

It is indeed deplorable that in a lesion about which we know so much and which occurs as frequently as cancer of the stomach we have not been able to accomplish more as regards cure. The principal reason, I am sure, is that there is a long delay from the onset of the first symptoms until definitive therapy is instituted and that other

From the Department of Surgery, Tulane University School of Medicine, and the Ochsner Clinic, New Orleans.

Read before the Florida Medical Association, Eighty First Annual Meeting, St. Petersburg, April 4, 1955

lesions are diagnosed when gastric cancer should be suspected. In our series there was a delay of 8.4 months. In Safar and Cliffton's series[10] there was a delay of 8.3 months. Twenty per cent of the patients were treated from one to nine months without a roentgenogram being taken, and in 20 per cent a roentgenogram was taken, but the patient was treated for varying periods of time without cancer being suspected. In 60 per cent, however, the physician was not responsible for the delay. Gray and Ward[12] reported an average delay of 7.8 months before a physician was consulted and an additional delay of 6.4 months on the part of the physician before a correct diagnosis was made. If better results are to be obtained in the treatment of cancer of the stomach, it is imperative that physicians consider the possibility of a malignant gastric lesion in all persons, particularly men past 40 years of age, who have gastric distress which persists in spite of therapy.

Type of Resection

Within recent years much emphasis has been placed on the necessity of wider resections for malignant lesions of the stomach with the hope that by increasing the extent of the resection, particularly by total gastrectomy in all malignant gastric lesions, more cures can be obtained. We are convinced from our experience that, although obviously it is necessary to perform a good cancer operation, which consists of a radical removal of all the tumor-bearing area of the stomach together with an en bloc excision of sites of metastasis, as much can be accomplished by a radical subtotal gastrectomy in most gastric cancers as can be by total gastrectomy. The former procedure is certainly to be preferred if the curability incidence is as high as with a total gastrectomy, because maintenance of a small gastric pouch, which is accomplished by radical subtotal gastrectomy, greatly minimizes the digestive disturbances which follow total gastrectomy. It is unfortunate, however, that the profession has come to use the term subtotal gastrectomy loosely, and apparently it can denote anything from a "biopsy" to a good cancer operation.

One reason why more radical operations are recommended is because of local recurrence in the remaining stump of the stomach following "subtotal" gastrectomy. Walters, Gray and Priestley[13] found recurrence in and about the stomach in a series of 120 cases of gastric carcinoma in which the patient was subjected to resection. Similarly, Stout[11] found local recurrence with no evidence of distant metastases in 3 of 8 cases coming to autopsy six or more months after subtotal gastrectomy. McNeer, VandenBerg, Donn and Bowden[15] found local recurrence either in the wall of the stomach or at the gastrojejunostomy following gastrectomy for gastric carcinoma in 92 patients. It is of importance to emphasize, however, that in 60 cases in which it was possible to determine the extent of the resection, there was local recurrence in 44 cases. Of these, in 7 (15.9 per cent) less than one fourth of the stomach was resected, in 15 (34.1 per cent) one half was resected, in 20 (45.5 per cent) one half to three fourths was resected, and in only 2 (4.5 per cent) was more than three fourths resected. In other words, in 42 (95 per cent) of the 44 cases in which there was local recurrence only three fourths or less of the stomach had been removed. Obviously, these statistics cannot be used as an argument for total gastrectomy and against a good cancer operation, which consists of radical removal of all except a small portion of the stomach together with the regional lymph nodes.

For some time we have been convinced that a good cancer operation for malignant lesions of the stomach can be accomplished in lesions of the distal half of the stomach, if all of the stomach except a very small portion of the greater curvature is removed together with the adjacent omenta (gastric, hepatic, gastrocolic and greater omentum), the first portion of the duodenum, the spleen and all of the regional lymph nodes. The lymph nodes which should be carefully removed are those around the celiac axis, the left gastric vessels, the gastrolienal ligament, and the esophagus, and those in subpyloric and subhepatic areas. It is important that the first portion of the duodenum should be removed, because, contrary to what was formerly thought, it is now known that carcinoma of the distal part of the stomach can infiltrate into the duodenal wall. Konjetzny[16] found the duodenum involved in 67 per cent of his cases of gastric cancer. Coller, Kay and MacIntyre[17] found the duodenum involved in 26.4 per cent of patients in whom a gastrectomy for carcinoma had been performed. Harvey, Titherington, Stout and St. John[18] found that in one fourth of antral carcinomas the duodenum was invaded. Eguia[19] emphasized that the intramural type of cancer extends submucously and subserously for great distances beyond the gross lesion and he found involvement of the duodenum

in 37 per cent of his cases. Castleman[20] reported a high incidence of involvement of the duodenum in his cases, but emphasized that the involvement was seldom more than 1 cm. in extent.

If a radical subtotal resection is performed, we are convinced that as much can be accomplished in the distally located lesion as by total gastrectomy. The remaining pouch, which is usually no larger than one's thumb, is actually not much of a reservoir, but the patients have minimal symptoms, probably because some of the left vagus fibers remain intact. In lesions located in the proximal half of the stomach, however, and probably in all diffusely infiltrating lesions (linitis plastica) a total gastrectomy is necessary, although in these cases even this procedure does not give good results.

Time Lag Factor

The diagnosis of gastric cancer is frequently difficult to make at a time when the lesion is still curable in spite of the frequently made statement that gastric cancer can be diagnosed in over 90 per cent of cases by roentgen examination. The statement is undoubtedly true if one waits until the lesion is large enough and characteristic enough to produce a typical roentgen appearance of gastric cancer. It is our conviction, however, that the early diagnosis of gastric cancer is difficult and that if better results are to be obtained in the treatment of gastric cancer, a gastric lesion must be treated while it cannot be diagnosed as cancer by the presently available clinical means. The fact that there is a delay of well over six months from the onset of the first symptoms until definitive therapy is instituted substantiates this contention. It is only when this delay can be decreased to a few weeks or at most a month or two that the results in the treatment of gastric cancer can be improved.

Precancerous Gastric Lesions

There are certain lesions of the stomach that are precancerous. It is a well known fact that gastric polyps are definitely premalignant and should always be removed. Cromer, Comfort and Butt[21] found in a series of 195 cases of adenomatous gastric polyps that 20 per cent were malignant. The lesions in certain cases of gastritis are definitely premalignant. Konjetzny[16] believed that 85 per cent of gastric cancers develop upon the basis of chronic gastritis, and he considered chronic gastritis a premalignant lesion. According to Orator,[22] 80 per cent of gastric carcinomas originate in chronic gastritis. Puchert[23] and Hurst[24] were of the same opinion. Persons who have pernicious anemia have a higher incidence of gastric cancer than those who are not so afflicted. Rubin and Hodges[25] found that among 1,320 cases of pernicious anemia treated at the University of Michigan Hospital there were 35 in which gastric cancer was present, an incidence of 2.5 per cent, which is 10 times that found in the general hospital population. They stated that gastric carcinoma in patients with pernicious anemia is usually in the fundus or body, and they believed that the gastritis is definitely precancerous. Schell, Dockerty and Comfort[26] reported 94 cases of gastric carcinoma in patients with pernicious anemia. They stated that carcinoma associated with pernicious anemia differs from gastric carcinoma in persons without pernicious anemia in that in the former the lesion tends to be polypoid and is usually multicentric, usually located in the fundic or cardiac areas, usually of a lower grade and frequently a mixture of grades, and symptoms occur relatively late.

There is considerable controversy as to whether a gastric ulcer is a precancerous lesion or not. Stout,[14] in 82 gastrectomies performed for cancer, found evidence in 12.4 per cent that the cancer had developed at the margin of a pre-existing ulcer. Ekström[27] similarly found evidence in 138 gastrectomies for cancer that the cancer developed from a benign ulcer in 16 (11.5 per cent). In 15 per cent of all his cases there was a great likelihood that a previous ulcer had existed, and in 8 per cent there was unquestionable evidence of a pre-existing ulcer. On the other hand, Brown, Fisher, and Hazard[28] found only eight instances (1.1 per cent) in 715 cases of gastric ulcer at the Cleveland Clinic. Swynnerton and Truelove,[29] in a series of 375 cases of gastric cancer, found that 26 (7 per cent) of the lesions arose in a gastric ulcer. Deloyers and Moyson[30] stated that 10 per cent of all gastric ulcers become malignant. Hess[31] stated that 8 per cent of all gastric ulcers are malignant and only half of these can be recognized as malignant. He believed that frozen section should be made of all gastric ulcers at the time of operation in order not to miss the malignant lesion. We are of the opinion that frozen section at operation is of little value because of the possibility of missing the carcinoma.

We also believe that gastric ulcers are precancerous lesions and that a benign ulcer can undergo malignant change. Although at the pres-

ent time the consensus is that benign ulcers seldom become malignant and that a carcinomatous ulcer was malignant from the beginning, it is not difficult to imagine that the persistence of an ulcerative lesion in an epithelial membrane such as gastric mucosa, which is so susceptible to malignant change, may become malignant similarly as a cutaneous ulcer becomes malignant after some time. Whether benign ulcers become malignant or not, the fact remains, however, that it is impossible in many instances to determine clinically whether a gastric ulcer is benign or malignant. According to Allen[32] and Cain, Jordan, Comfort and Gray[33] approximately 10 per cent of small ulcers of the stomach are malignant. Engel[34] stated that the roentgenologist was unable to differentiate between benign and malignant ulcers in 34 per cent of his cases. In a series of 550 cases of clinically benign gastric ulcers reported by Lampert, Waugh and Dockerty[35] from the Mayo Clinic, 73 (13 per cent) proved to be malignant. For a number of years I have been convinced that all gastric ulcers regardless of their size and location should be treated surgically, first, because of the inability of the clinician, the roentgenologist or the gastroscopist to differentiate between a benign and malignant ulcer, and second, because the results following surgical treatment of gastric ulcer are usually good. Whereas there are many who are not willing to accept this philosophy, I believe that only by its adoption can the curability rate of cancer of the stomach be materially increased.

The undesirability of treating gastric ulcers conservatively is shown by an excellent study by Cain and his co-workers.[33] Of 414 cases of gastric ulcer which were followed carefully at the Mayo Clinic, the five year results were as follows: only 20 per cent of the patients had complete relief; 17.2 per cent had partial relief; 14.7 per cent were unimproved, and 8.9 per cent were worse, 15 of whom died of cancer and 9 of gastric cancer. In 78 cases in which operation was suggested but refused and in which conservative therapy was used, the results were satisfactory in only 11.6 per cent, in 84.6 per cent they were unsatisfactory, in 3.8 per cent they were unknown, and in 12.8 per cent the presence of carcinoma was established. Surgery was subsequently used in 56.1 per cent. In 336 cases in which medical therapy was advised the results were satisfactory in 22.6 per cent, unsatisfactory in 72.3 per cent and unknown in 5.1 per cent; the lesion was found to be cancerous in 9.8 per cent. Surgical therapy was subsequently employed in 42.4 per cent of the unsatisfactory group. These authors concluded that the results from medical treatment in gastric ulcer are not good because only 85 of the patients in their cases obtained complete relief, 309 had unsatisfactory results, 140 subsequently had to be operated upon, 15 of 274 who received only medical treatment died from related medical complaints, and 9 died of cancer. In 9 other cases the gastric cancer was found to be inoperable, and in 30 cases death was attributable to complications of the benign ulcer or to cancer. Cain and his associates[33] concluded that the chance of having a gastric carcinoma is 100 times greater in a person who has a small gastric ulcer than in one who has no ulcer. It is obvious that the physician who elects to treat a gastric ulcer by conservative measures assumes a tremendous responsibility because of the great likelihood that the lesion may be malignant.

Analysis of Series

From 1942 to 1954, 258 cases of primary gastric malignant disease were observed in the Ochsner Clinic, of which 95.7 per cent were cases of carcinoma, 1.9 per cent leiomyosarcoma, 1.2 per cent reticulum sarcoma, and 0.4 per cent each lymphosarcoma, Hodgkin's disease, and neurofibrosarcoma. Of the 247 patients with carcinoma 68.5 per cent were men, and 31.5 per cent were women. The average age for the men was 57.8 years, and that for the women was 59.9 years. In the men, the disease occurred in 13.5 per cent before the age of 50 years and in 68 per cent between the ages of 50 and 70 years. In the women, it occurred in 17 per cent before the age of 50 years and in 54 per cent between the ages of 50 and 70 years. Of the 247 cases of epithelial tumors (carcinoma) the lesions in 236 were described by the pathologist as follows: in 155 (65.6 per cent) there was diffuse involvement, in 54 (22.4 per cent) the lesion was ulcerative, and in 27 (11.4 per cent) it was polypoid. In 162 cases reported by Moore and Morton[11] 50 per cent of the lesions were papillary, 35 per cent ulcerative, 8.6 per cent local infiltrating, and 5.5 per cent linitis plastica.

Unfortunately the diagnosis of gastric cancer is generally made late. In our 247 cases, there was an average duration of symptoms of 8.7 months from the first symptom until definitive therapy was instituted. Loss of weight, which aver-

aged 25.7 pounds, occurred in 90 per cent of our cases. Although Moore and Morton[11] believed that loss in weight is a late manifestation, we are not of this opinion. We think that anorexia severe enough to produce this loss frequently is an early manifestation of gastric cancer. In Moore and Morton's series it was present in 69 per cent. Safar and Cliffton[10] also were of the opinion that loss in weight is not necessarily a bad sign because 60 per cent of their patients who were apparently well five years after gastrectomy had this loss, and it was the most frequent manifestation in their series of cases of gastric cancer. In addition to loss in weight, the other symptoms in our series were: pain, 85 per cent; nausea, 58 per cent; tenderness, 55 per cent; anorexia, 52 per cent; simple vomiting, 47 per cent; palpable mass, 45 per cent; retention vomiting, 20 per cent; melena, 19 per cent; and dysphagia, 16 per cent.

Diagnosis

As mentioned previously, it is not difficult to make a diagnosis of gastric cancer if the condition is only considered. Unfortunately, as a rule there is considerable delay before gastric cancer is suspected. The statement is frequently made that roentgen examination is the most valuable method of making a diagnosis, and in our cases gastric carcinoma was diagnosed by the roentgenologist in 96.6 per cent. Finby and Eisenbud[36] emphasized that lesions in the proximal third of the stomach are particularly difficult to diagnose. In their series of cases, cancer was correctly diagnosed in 83 per cent when the lesion was in the distal two thirds of the stomach, but in 15 per cent in which the lesion was in the proximal third there was misinterpretation concerning the findings, and in 13 per cent the lesion was completely missed. Roentgen examination gave positive evidence in 92 per cent of Moore and Morton's cases.[11] René Gutmann[37] of Paris believed that gastric cancer can be diagnosed roentgenographically relatively early in its course. He was of the opinion that in the beginning its growth is extremely slow and a long time is required for the classical roentgenographic picture to develop. Although a correct diagnosis was made by roentgen examination in approximately 97 per cent of our cases, we believe that usually gastric cancer should be treated before the roentgenographic findings are positive. Unquestionably most, if not all, gastric carcinomas are diagnosable by roentgen study if there is enough delay for the lesion to extend sufficiently to produce the typical picture, but by that time the lesion is usually not curable.

Other laboratory findings may be of value. Gastroscopic examination is probably indicated in all suspected cases of gastric cancer, but unfortunately it frequently is of little value in making a positive diagnosis. Whether the availability of an operating gastroscope by means of which biopsies can be obtained will increase the number of correct diagnoses can be determined only after there is considerably more experience than is now available. Unfortunately, up to the present time, an ulcerative lesion of the stomach which might be benign or malignant cannot generally be differentiated gastroscopically. Equally disappointing has been the cytologic examination of the gastric secretion. It was hoped that the newer methods of obtaining cytologic material, such as the abrasive balloon technic of Panico, Papanicolaou and Cooper,[38] would give better results, but up to the present time such has not been the case.

Gastric acidity is frequently determined to differentiate between benign and malignant lesions of the stomach. Although many malignant lesions of the stomach are associated with achlorhydria, not infrequently the gastric acidity is normal. Moore and Morton[11] found free hydrochloric acid in 34 per cent of the cases which were studied, and Vittadini[39] found that the gastric acidity varied according to the type of lesion. In 350 cases of gastric cancer it was found that in the fungating and infiltrating tumors free hydrochloric acid was present in 12.8 per cent and 23.3 per cent, respectively. In ulcerative lesions, however, free hydrochloric acid was found in 52.2 per cent, and in many cases the values were higher than are normally found. The finding of gastric acidity, therefore, in no way excludes a gastric carcinoma and cannot be used in differential diagnosis.

We believe that there are some patients, a small number to be sure, in whom a presumptive diagnosis of gastric carcinoma is justified even though all laboratory methods give negative results. I refer especially to a man past 40 years of age who previously had had no gastric symptoms, who was able to eat anything without difficulty, and who for the first time experienced gastric symptoms, particularly anorexia, severe enough to make him lose weight of 10 or more pounds within a period of a few weeks in spite of therapy. In such a person, although there may be no roent-

genologic or gastroscopic evidence of a gastric lesion, a diagnosis of gastric cancer must be considered until proved otherwise, and the patient should be given the advantage of an abdominal exploration. We have had four such patients and in each instance a small cancer which was not large enough to be visualized roentgenographically was found. A radical subtotal gastrectomy was performed with what we believe is a cure. Had we waited until the lesion had become clinically diagnosable as cancer, we think the lesion would have become inoperable.

Therapy

Of the 247 cases of gastric carcinoma included in the present report, in 13.4 per cent the lesion was so far advanced when the patients were first seen that it was considered inoperable. In 16 (7 per cent) of the remaining 214 cases, the patient refused surgery or returned home to be operated upon. In 198 cases exploration was carried out. In 107 (54 per cent) the lesion was found to be nonresectable; 16 (15 per cent) of the patients in this group died in the hospital. In 91 cases a resection was performed, and in 60 (66 per cent) it was designated as a palliative resection because there was evidence of extension beyond the stomach. In the 60 cases in which a palliative resection was carried out, the operation in 39 (65 per cent) was subtotal gastrectomy, in 13 (21.6 per cent) total gastrectomy, and in 8 (13.3 per cent) esophagogastrectomy. In 9 (15 per cent) of these 60 cases the patient died in the hospital. The high mortality rate in these cases was due to the extent of the disease and was not due to the operative treatment per se. In 31 cases the resection was considered curative because there was neither gross nor microscopic evidence of extension beyond the stomach. In 26 (83.8 per cent) the treatment was subtotal resection with 2 deaths (7.7 per cent) in the hospital and 24 patients (92.3 per cent) leaving the hospital; in 4 (13.5 per cent) total gastrectomy was performed and in (3.2 per cent) esophagogastrectomy with recovery; all patients survived.

To recapitulate, of the 247 cases of gastric cancer, in 44.1 per cent the treatment was a palliative procedure (esophagogastrectomy, 3.2 per cent; total gastrectomy, 5.3 per cent; subtotal gastrectomy, 15.8 per cent; and 20 per cent, some other palliative procedure such as gastrojejunostomy); in 23 per cent it was exploration and biopsy; in 17.5 per cent the operation was not warranted or was refused, and in only 12.1 per cent was a curative resection possible. In Moore and Morton's 163 cases[11] in which a resection was performed, in 49.2 per cent the procedure was subtotal curative resection, in 40.4 per cent palliative resection, and in 9.8 per cent total gastrectomy. In our series of 247 cases resection was performed in 91, as a palliative procedure in 60 and as a curative procedure in 31, giving a resectability incidence of 37 per cent. This compares favorably with Moore and Morton's resectibility incidence of 38.2 per cent. Blomquist[6] observed an increase in the resectability incidence from 38.2 per cent in the period 1926 to 1945 to 41.4 per cent in the recent period 1950 to 1952. He emphasized, however, that in the later period the treatment was instituted earlier than in the earlier period. Resectability incidence in Safar and Cliffton's series[10] was 34.5 per cent. Winkelbauer[10] reported a resectability incidence of 54 per cent. Lawton and his associates[2] reported a resectability incidence of 30 per cent, Pack,[11] 35 per cent, and Clark,[7] 25 per cent.

Survival Rates

The survival rates following any type of therapy are important criteria concerning therapy, particularly so in malignant disease. The fact that a patient simply survives a particular procedure is of little importance unless the long term survivals are significant. In determining long term survivals, we have assumed that every patient dying after therapy has died of the disease. This obviously is not the case because in these older age groups only approximately 85 per cent of the general population, whether they have gastric cancer or not, are alive at the end of five years. The survival rates in our cases, therefore, are actually better as far as the disease is concerned than the figures would indicate. Of our 247 cases, 238 (96.3 per cent) were followed. Of the 9 patients lost to follow-up, none had a chance of cure because in none was gastric resection performed. Of the group of patients in whom no resection was performed and in whom obviously the disease was most advanced, only 23.3 per cent were alive at the end of six months, 4 per cent were alive at the end of a year, and only 1 in a group of 128 (0.7 per cent) was alive at the end of two years. No patient lived as long as three years.

In the group of patients in whom some type of resection was performed, 71 per cent were alive at the end of two years and 21 per cent at the

end of five years. This number includes the patients subjected to radical subtotal resection and also those subjected to total resection. In the patients undergoing radical subtotal resection alone, survival rates were better probably because total gastrectomy was used more in the extensive lesions. Seventy-five per cent survived six months; 65 per cent, one year; 53 per cent, two years; and 37 per cent, five years. It is thus seen that better results were obtained in patients in whom radical subtotal resection was performed than in those subjected to both radical subtotal and total resection. As might be expected, the results in the patients undergoing palliative subtotal resection were not as good as those in patients in whom the resection was apparently performed for cure. Seventy per cent survived six months; 54 per cent, one year; 40 per cent, two years; and 12 per cent, five years. In Moore and Morton's series[11] the five year survival rate in the patients subjected to palliative resection was 19.5 per cent, and in the series reported by Safar and Cliffton[10] it was 6.9 per cent.

As might be anticipated, the results were much better in patients undergoing curative subtotal resection when there was no gross or microscopic evidence of extension beyond the stomach. Eighty-one per cent survived six months; 80 per cent, one year; 70 per cent, two years, and 57 per cent, five years. The five year survival rate in the patients subjected to curative subtotal resection reported by Moore and Morton[11] was 37.5 per cent, and that reported by Safar and Cliffton[10] was 32.5 per cent.

There is considerable variation in the length of survival according to the type of lesion. Patients with diffuse lesions survive the shortest periods of time, which might be expected because they have more extensive lesions. Of this group in our series, 29 per cent survived six months; 13 per cent, one year; 5.3 per cent, two years, and only 1.8 per cent, three years. No patient lived as long as four years. Moore and Morton[11] found in 9 cases of linitis plastica that none lived as long as one year. Of 14 patients having a localized, infiltrating lesion, 2 survived five years (14 per cent). Those with polypoid lesions in our series fared better: 48 per cent survived six months; 36 per cent, two years, and 23 per cent, five years. In Moore and Morton's series,[11] 12 (14.6 per cent) of the 82 patients survived five years. Pack and McNeer[12] reported that of patients with polypoid gastric cancer, 26.3 per cent survived five years. The results following resections for ulcerative lesions also were good. In our series, 70 per cent survived three months; 52 per cent, one year; 46 per cent, two years, and 22 per cent, five years. In Moore and Morton's series[11] of 57 patients with ulcerative lesions, 28 per cent survived five years. Pack and McNeer[12] reported a five year survival rate in 33.9 per cent of patients with ulcerative gastric cancers.

As might be anticipated, fewer patients with lymph node involvement survived five years than those without lymph node involvement. Only 12 per cent of our patients in the former group were alive five years following radical subtotal gastric resection, whereas 57 per cent of the latter group survived five years. Pack and McNeer[12] obtained a five year survival rate of 24.2 per cent in those with nodal involvement and 42.8 per cent of those without nodal involvement. In Safar and Cliffton's series,[10] 16.6 per cent of those with nodal involvement survived five years and 71 per cent of those without nodal involvement survived five years. Safar and Cliffton's statistics,[10] however, do not include the operative fatalities, which should indeed be included in a consideration of survivals in any lesion treated by operation.

The lymph node metastases apparently vary according to the type of malignant gastric lesion. In 118 cases of papillary carcinoma reported by Moore and Morton,[11] lymph node metastases were present in 44 per cent. In 82 cases with ulcerative lesions, the lymph nodes were involved in 41 per cent; and in 31 cases with local infiltrating lesions, there was lymph node involvement in 80.6 per cent. In only 5 of 12 cases of linitis plastica (41 per cent), however, was there lymph node involvement. It has been our experience that in cases of diffusely infiltrating lesions, such as linitis plastica, even though there may not be demonstrable lymph node involvement at the time of the resection, the chance of obtaining a cure is not great, and not infrequently retrograde permeation of the lymphatics of the entire gastrointestinal tract with tumor cells will subsequently become evident. This result is undoubtedly due to the fact that obstruction to the normal drainage of the lymph system occurs, resulting in retrograde permeation throughout the lymphatics within the intestine.

Summary

To summarize the results obtained in the present series, exploration was carried out in 80.3 per cent of the cases and gastric resection in 37 per cent; 32.4 per cent of the patients survived the resection, and 7.2 per cent are alive at the end of five years. These results are not satisfactory, but when one recalls that there was an average delay of 8.4 months from the onset of symptoms until definitive therapy was instituted, it is evident why the results are bad. The fact that a five year survival rate of 57 per cent was obtained in those cases in which a radical subtotal resection was performed and in which the lesion was limited to the stomach demonstrates that if the diagnosis of gastric cancer can be made at a time when the lesion is still limited to the stomach, the results will be good.

It is, therefore, imperative that the physician treating a patient with gastric symptoms should consider the possibility of gastric carcinoma early in the course of the condition and should not wait until the classical manifestations of carcinoma are evident. If one waits until the lesion can be diagnosed clinically as cancer, there is usually a delay of several months, and the therapeutic results will be bad. On the other hand, if lesions of the stomach which are definitely precancerous lesions, such as polypi, gastric ulcers, gastric anacidity, particularly associated with pernicious anemia, and gastritis in certain cases are looked upon with suspicion and in many instances subjected to resection, early malignant gastric lesions will be treated at a time when the lesion is still limited to the stomach. This observation is particularly true of gastric ulcers. Although one would not be justified in subjecting all patients with pernicious anemia and associated gastritis to gastric resection, we think that one is obligated to subject all patients with chronic gastric ulcers and gastric polypi to gastric resection. The fact that 10 per cent of gastric ulcers are malignant and that in all gastric ulcers it is impossible to determine clinically whether malignant change is present or not indicates that conservative therapy is not justified.

Also, there are patients, men past 40 with minimal but persistent gastric symptoms which do not respond to therapy resulting in loss in weight of 10 or more pounds within four to eight weeks, in whom there is no roentgen evidence of a gastric lesion, and in whom gastroscopy is normal and gastric acidity is normal, who should be given the advantage of abdominal exploration to determine the presence or absence of a malignant lesion in the stomach. It is only by treating gastric lesions, which are clinically not cancer, by suspecting cancer of the stomach in patients with bizarre gastric complaints, and by subjecting them to abdominal exploration that the curability incidence of cancer of the stomach will be increased.

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Acute Abdominal Disease

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Acute abdominal disease presents an emergency, occurring often at night when the physician is fatigued as the result of a busy day. The life of his patient, however, often will depend upon his most careful, intelligent study of the condition and a wise choice of definitive treatment. Some of the most difficult surgical procedures are sometimes performed under these circumstances.

An orderly plan for diagnosis of acute abdominal disease is most important and should be considered under four simple headings:[1]

1. History
2. Present symptoms
3. Physical examination
4. Laboratory and x-ray data

Pain is usually the predominant symptom. One should determine the time of onset, whether gradual or sudden, its severity, and its type and duration, whether constant or remittent. Constant pain is produced by edema, while remitting colicky pain is due to obstruction, which usually requires early surgery.

The type of vomiting, whether early, late, profuse or projectile, is important, as well as the past or present character of the stools. While the patient is under observation or awaiting surgery, fluid, electrolyte and blood needs must be supplied.

Time will permit only a brief discussion of the more frequently confusing abdominal conditions, which will include acute appendicitis, perforated peptic ulcer, acute cholecystitis, acute intestinal obstruction, mesenteric occlusion, acute pancreatitis and peptic ulcer hemorrhage. The discussion of treatment will be limited to that usually rendered by the surgeon in the emergency.

Acute Appendicitis

The typical textbook picture of acute appendicitis will not be repeated here. It may resemble almost any other abdominal disorder, including cholecystitis, diverticulitis, acute amebiasis, or even a perforated malignant lesion.[2]

Anorexia[1] is probably a more important constant finding than nausea and vomiting. A sense of complete cessation of intestinal function is suggestive.[2] Elevation of the leukocyte count is an aid, but should not always be depended upon as it may remain near normal.

Tenderness in the flank usually indicates a high-lying retrocecal appendix, while tenderness

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in the pelvis suggests a low-lying appendix.[2] Localized tenderness, muscle defense, and rebound tenderness are the most important findings. The iliopsoas sign which indicates a pathologic condition in the retrocecal region, the obturator test, pathologic change in the pelvis and Rovsing's sign of pressure over the left lower quadrant producing pain in the cecal region are helpful in locating the inflamed appendix.[1] Treatment of course is surgical.

Perforated Peptic Ulcer

A history of previous ulcer symptoms or diagnosis, or previous gastric hemorrhage or tar stools, may be obtained. The attack occurs usually after eating, the pain being sudden and severe and beginning in the epigastrium. There is a board-like abdomen with moderate to severe shock and absence of peristalsis.

Diagnosis is made from the history and physical findings, and if possible is confirmed by roentgen examination demonstrating subdiaphragmatic air. Immediate operation is indicated. If the operation is performed early, the patient is in excellent physical condition, and the operating room setup is ideal, subtotal gastric resection may be carried out. Simple closure of the perforation is the usual procedure for duodenal ulcers, but, if at all possible, gastric resection is desirable for gastric ulcer because of the possibility of malignancy.[2]

Acute Cholecystitis

Patients with acute cholecystitis usually have a history of selective dyspepsia. The usual offenders are fried and fatty foods, raw apples, cucumbers and cabbage. They complain of bloating and belching. They are usually women who have been pregnant, and are fair, fat and forty. Physicians all know exceptions occur.

The pain is either colicky, indicating obstruction, or constant, indicating edema, and is usually located under the right costal margin. It may be referred to the splanchnic region and confused with peptic ulcer, or coronary occlusion, or it may be radiated along the seventh intercostal nerve to the inferior angle of the right scapula or interscapular region. Additional symptoms are fever, nausea, vomiting, localized tenderness and muscular rigidity in the right upper quadrant of the abdomen. Ligat's test, hyperesthesia over the area of pathologic change may aid in diagnosis.[1]

Immediate treatment includes a smooth muscle relaxing agent such as amyl nitrite, 1/100 grain nitroglycerin, Demerol, papaverine and other drugs. Morphine should be avoided. Hydration, electrolytes and antibiotics are administered. Differential diagnosis may be aided by roentgen examination of the area of the diaphragm to rule out pneumonia and stones.

Immediate operation, within 36 to 48 hours, depends upon the progressiveness of the following symptoms and findings:[2]

1. Sustained pain
2. Persistence of a palpable, tender mass in the right upper quadrant, with abdominal rigidity
3. Continued elevation of temperature and a rising leukocyte count
4. Lack of clinical improvement

Operation probably should be performed in less severe cases if no improvement is evident within 72 hours. If at operation cholecystectomy seems too hazardous, cholecystostomy may be life-saving, particularly in the aged.

Acute Intestinal Obstruction

When acute intestinal obstruction is present, there may be a history of previous surgery; symptoms of colicky abdominal pain, nausea and vomiting; and findings of hyperperistalsis, distention, some rigidity, and little if any tenderness. These and roentgenograms of the abdomen all should aid in the diagnosis. Gastric intubation and fluid and electrolyte replacement should be carried out early. If early relief is not obtained, operation is imperative.

Mesenteric Occlusion

This condition is caused primarily by embolism, usually observed in patients with arteriosclerosis, myocarditis, vegetations on the valves, or some other vascular or cardiac disorder. The symptoms are similar to those of intestinal obstruction, and the pain, usually located in the midabdomen, is gnawing in character and unremitting. In the early hours there are hyperperistalsis, nausea, vomiting and at times diarrhea, occasionally with blood. Later there is localized tenderness, accompanied by involuntary muscle spasm, and the abdomen is silent.[2]

Diagnosis is aided by a low serum amylase level, electrocardiographic examination and a plain film of the abdomen to demonstrate the dilated intestine and lack of air under the dia-

phragm. Symptoms may be confused with those of coronary thrombosis, acute pancreatitis and perforated peptic ulcer.[2] Early surgery is necessary with wide resection of the involved bowel.

Acute Pancreatitis

Usually occurring in stout persons, acute pancreatitis is more often observed in women over 40 years of age.[1] There may be a history of previous attacks which have been diagnosed as gallbladder disease. The etiology is often obscure. Some of the causes which have been mentioned are:[3]

1. Obstruction or spasm of the ampulla of Vater
2. Obstruction of pancreatic ducts, stones, tumor, infection and duodenal diverticula
3. Alcoholism
4. Anaphylaxis

The onset is sudden with excruciating epigastric pain and persistent nausea and vomiting, which may be followed by cyanosis and shock in the hemorrhagic type. It usually follows the ingestion of a heavy meal. The pain may be referred to the back, but generally radiates to one or both loins. It is relieved somewhat when the patient sits up or lies on his abdomen and is aggravated when he is on his back.

Physical examination reveals a patient cold, clammy, with subnormal temperature, rapid, thready pulse and in a state of shock. The physical findings of the abdomen are mild compared with the severity of the symptoms. Some epigastric tenderness and muscular defense are present, but one feels a doughy consistency rather than rigidity.[2] Peristalsis is quiet, but the abdomen is not immediately silent. Mild jaundice occurs in 25 per cent of the cases. Other physical findings sometimes observed are Cullen's sign, bluish discoloration in the periumbilical area on the third or fourth day in a small percentage of the cases, and the Grey-Turner sign, bluish discoloration in the flanks.[3]

There are two types: (1) acute edematous pancreatitis, which is relatively mild, and (2) the acute hemorrhagic type, which is severe and may be fulminating.

Laboratory Data. — Moderate leukocytosis with increased neutrophils is commonly present. Hemoconcentration early accompanies severe attacks. An elevated serum amylase level occurs early, within two hours with a maximum of 24 to 28 hours after the onset. The urine amylase level is normal at first, but becomes elevated later and remains so after the diastatic activity of the serum has returned to normal. Increases in serum and urinary lipase occur, but are not consistent. The blood calcium may be depressed. Hyperglycemia and glycosuria may occur in the severe cases. Widening of the duodenal loop, accumulation of gas in the duodenum, elevation of the stomach, irritability and spasm of the midcolon, stones in the gallbladder, biliary ducts or pancreatic ducts, calcification of the pancreas and some fixation of the diaphragm are possible roentgen findings.[3]

Differential Diagnosis. — Diagnosis is suggested by the severity of the symptoms and the relative mildness of local physical findings early in the course of the disease. It may be confused with:[4]

1. Acute cholecystitis with or without perforation
2. Perforated peptic ulcer
3. Acute intestinal obstruction
4. Mesenteric occlusion or other vascular disorders including coronary occlusion

Other conditions with which it may be confused, but which will not be discussed, are: acute appendicitis, acute generalized peritonitis, renal colic, pneumonia and tabetic crisis.[5]

1. Acute Cholecystitis. — During an attack of acute pancreatitis exudate from the inflamed pancreas pours through the foramen of Winslow and produces inflammatory reaction about the liver, gallbladder, duodenum, pylorus and transverse colin. These structures together with the omentum may form a tender mass, producing a situation practically identical with acute cholecystitis. Indeed, the patient may have gallstones and may be suffering from associated disease of the biliary tract. While supportive measures are being carried out and laboratory data collected, a careful history is made of previous symptoms, for example, pain lasting days instead of hours, attacks followed by diarrhea or transitory jaundice, and nonvisualization of the gallbladder roentgenographically during attacks with normal cholecystograms during the intervals between attacks.

Immediate treatment in preparation for possible surgery includes:

(1) Hydration and electrolyte replacement

(2) Levin tube with continuous gastric suction
(3) Atropine and the nitrites
(4) Sedation (Demerol)
(5) Antibiotics

Immediate laboratory work should include, in addition to routine blood and urine studies, tests for serum amylase, sugar and carbon dioxide combining power and serum calcium and examination of the urine for acetone and bilirubin. A high serum amylase level indicates pancreatitis. A high blood sugar level and low carbon dioxide combining power indicate acidosis due to an acute diabetes, resulting from pancreatitis. Roentgen studies may reveal a widening duodenal curve and calcification in the head or throughout the pancreas.

2. Perforated Peptic Ulcer. — Differential points include:

(1) History of previous ulcer
(2) Normal serum amylase
(3) Air seen under the diaphragm in an upright roentgenogram of the abdomen
(4) Physical findings of boardlike silent abdomen

3. Acute Intestinal Obstruction. — Differential points include:

(1) History of previous surgery
(2) Normal serum amylase
(3) Hyperactive peristalsis
(4) Plain film of the abdomen showing distended loops of small bowel correlated with (1), (2) and (3). Gastric suction and atropine should be given while the patient awaits diagnosis and possible surgery.

4. Mesenteric Thrombosis or Other Vascular Disorders Including Coronary Thrombosis. — A history of cardiac failure or other vascular disease and increasing symptoms of severe intestinal obstruction with low serum amylase level and absence of pronounced epigastric tenderness aid in the differential diagnosis. A dissecting aneurysm occasionally will produce this type of pain and must be suspected if it is to be diagnosed. Coronary thrombosis will be discussed by others; if it is suspected, an electrocardiogram is indicated.

Treatment. — The immediate medical treatment of acute pancreatitis has been outlined under the discussion concerning differential diagnosis from acute cholecystitis. Most surgeons agree that conservative medical treatment for acute pancreatitis is the treatment of choice and has saved many lives since it has become almost routine. Gage[3] reported good results in relief of pain with procaine block of sympathetic nerves. In my experience gastric suction with atropine and Demerol has produced early relief in the milder cases. In the hemorrhagic cases, indications for surgery according to Cattell and Warren[3] are:

1. Diagnosis in doubt
2. Suppuration present or suspected
3. Evidence of mechanical obstruction of biliary tree
4. Cystic accumulation evident

Bleeding From Peptic Ulcer

Fatal bleeding is more apt to occur in persons over 50 years of age but exceptions are frequent. The site of the hemorrhage in the gastrointestinal tract must be located if possible, and in this respect a careful history as well as physical examination is most important. Causes of hemorrhage other than ulcer include esophageal varices, blood dyscrasias, and benign and malignant tumors.

The history should include these important points:

1. Previous symptoms or diagnosis of peptic ulcer
2. Previous gastrointestinal bleeding with vomiting of blood, tar-colored stools or bright red blood in stools
3. Previous other type bleeding such as from hemorrhoids
4. History or symptoms of cirrhosis of the liver

To arrive at a diagnosis of bleeding peptic ulcer may be difficult or impossible; nevertheless, successful treatment usually will depend upon accuracy in this respect.

Indications for immediate surgery[6] are:

1. When bleeding continues after the patient has been on a strict medical regimen for 24 to 28 hours.
2. When bleeding starts while the patient is under strict medical treatment in the hospital.

Holman[6] reported a reduction in the mortality rate to 5 per cent after this policy was adopted. He believed that surgery should be considered only after a definite diagnosis of the site of the

hemorrhage has been made. During the period of observation and following surgery, close contact with the internist is most important. Steps taken while the patient is under observation include:

1. Adequate sedation
2. Immediate blood replacement
3. Nothing by mouth

At surgery, if all conditions are favorable, the operative procedure of choice is gastric resection, although simple suture of the bleeding vessel with plastic closure may be life-saving in the patient who is a poor risk.

Summary

The salient features of the diagnosis and treatment of frequently confusing acute abdominal diseases constituting emergencies are presented. The diseases discussed are acute appendicitis, perforated peptic ulcer, acute cholecystitis, acute intestinal obstruction, mesenteric occlusion, acute pancreatitis and hemorrhage from peptic ulcer.

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Do We Really Advise the Patient?

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The title poses a most intriguing question. What doctor has not been plagued over and over again for advice, only to have the same patient calmly ignore every suggestion made. Surely there have been times when most of you physicians have wondered if it was worth the time spent to advise better antepartum care, more milk, or whatever subject was involved. Do you recall the diabetic patient who refused to take his insulin? Or the gallbladder patient who ate exactly as he desired and then wondered why he suffered later? Or perhaps the mother who practically demanded treatment for "Little Johnny's" cold, and then let him run wild in the rain later the same day? Why do such persons seek, yet ignore your advice?

I would not be so presumptuous as to suggest an answer for all, or perhaps for any, of these questions. My recent investigations among one group, however, suggest an interesting factor that might be one reason for failure to follow advice. That factor is:

Nutrition Consultant, Florida State Board of Health.
Read before the Florida Health Officers' Society, Tenth Annual Meeting, St. Petersburg, April 4, 1955.

Do Your Patients Understand You?

There were 85,011 births in Florida during 1954. Many of you shared the responsibility for giving the mothers adequate advice on nutrition during the antepartum period, for there is much increased interest in the relationship between dietary intake and maternal and fetal outcome. Many studies[1-6] substantiate your interest in this field; but do your patients share your concern with diet? Do overweight and its accompanying hazards for the pregnant woman impress her enough to make her calorie conscious? The effects of dietary inadequacies fail to concern many of your patients. True, some are prompted to make changes; but consider the hundreds who continue to follow their own ideas regarding food choices. What prevents these patients from making the changes you suggest? Doubtless there are many answers. I would suggest the question mentioned: Do your patients understand you?

Are you employing professional language that is foreign to the patient? If she cannot understand you, do you really advise her? With these

questions in mind I decided to investigate the possibility that patients were not understanding much of the language used in giving nutrition advice.

Part I. Word Study

A list of 20 words frequently used in bulletins and by health department personnel in individual interviews was compiled (table 1). This list was reviewed by several nutritionists, nurses and physicians. They agreed it might be called typical of those words commonly used in talking with antepartum patients about their dietary intake.

Table 1. — Words Commonly Used in Advising Antepartum Patients About Dietary Intake

1. Nutrition	6. Vitamins	11. Lean meat	16. Proteins
2. Diet	7. Hemoglobin	12. Margarine	17. Starches
3. Pregnancy	8. Dried milk	13. Citrus fruits	18. Balanced diet
4. Maternity	9. Yellow vegetables	14. Enriched	19. Anemia
5. Well nourished	10. Constipation	15. Egg yolk	20. Rickets

Method

One hundred patients were interviewed by me. An informal friendly technic was used. Each patient was told the purpose of the interview; following her agreement to participate, she was asked the meaning of each word in table 1. After the word was stated, it was used in a sentence to assist the patient to grasp the meaning. Any reasonable definition was accepted. No time limit was placed on the length of the interview. No teaching was attempted except to explain what missed words meant if the patient requested an explanation.

No specific method of patient selection was attempted. Patients represented six counties in Northwest Florida in which I assist with nutrition and health programs. Each of these counties had a case load of antepartum patients that afforded me an opportunity to secure several interviews on one visit. Any cooperative patient who received public health services and who attended the health department clinic on the day of my visit was interviewed for the study. Obviously, such a sample cannot be termed typical of the entire state. Neither can statistically significant conclusions be drawn from the findings. The results, however, are such that certain implications may be drawn and pertinent suggestions made which should be of assistance in working with such a group of patients.

Analysis of Study

The patients, 5 white and 95 nonwhite, ranged in age from 15 to 46 years. Many had visited the health department clinics over a period of years. Although 97 patients stated that they could read, only 80 read either occasionally or regularly. Bible-reading was mentioned by many as the only reading done. Love stories and funny books were extremely popular reading material. Table 2 gives a detailed classification of the group.

The per cent of the total number of patients who had some understanding of each word is shown in figure 1.

Figure 2 indicates the comprehensive ability for the total group of words. It is interesting to note that 38 patients understood 50 per cent or less of the words. Fifty-five patients understood 35 to 60 per cent of the words. Only 17 patients understood 80 per cent or more of the 20 words listed as those commonly used in nutrition teaching in these clinics.

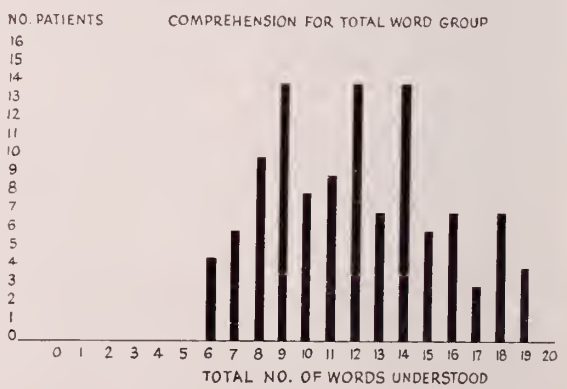


Fig. 2. — Among the total 100 patients, an average of 11.9 words was understood. Among the 45 rural patients, an average of 11.3 words was understood. Among the 55 urban patients, an average of 12.2 words was understood.

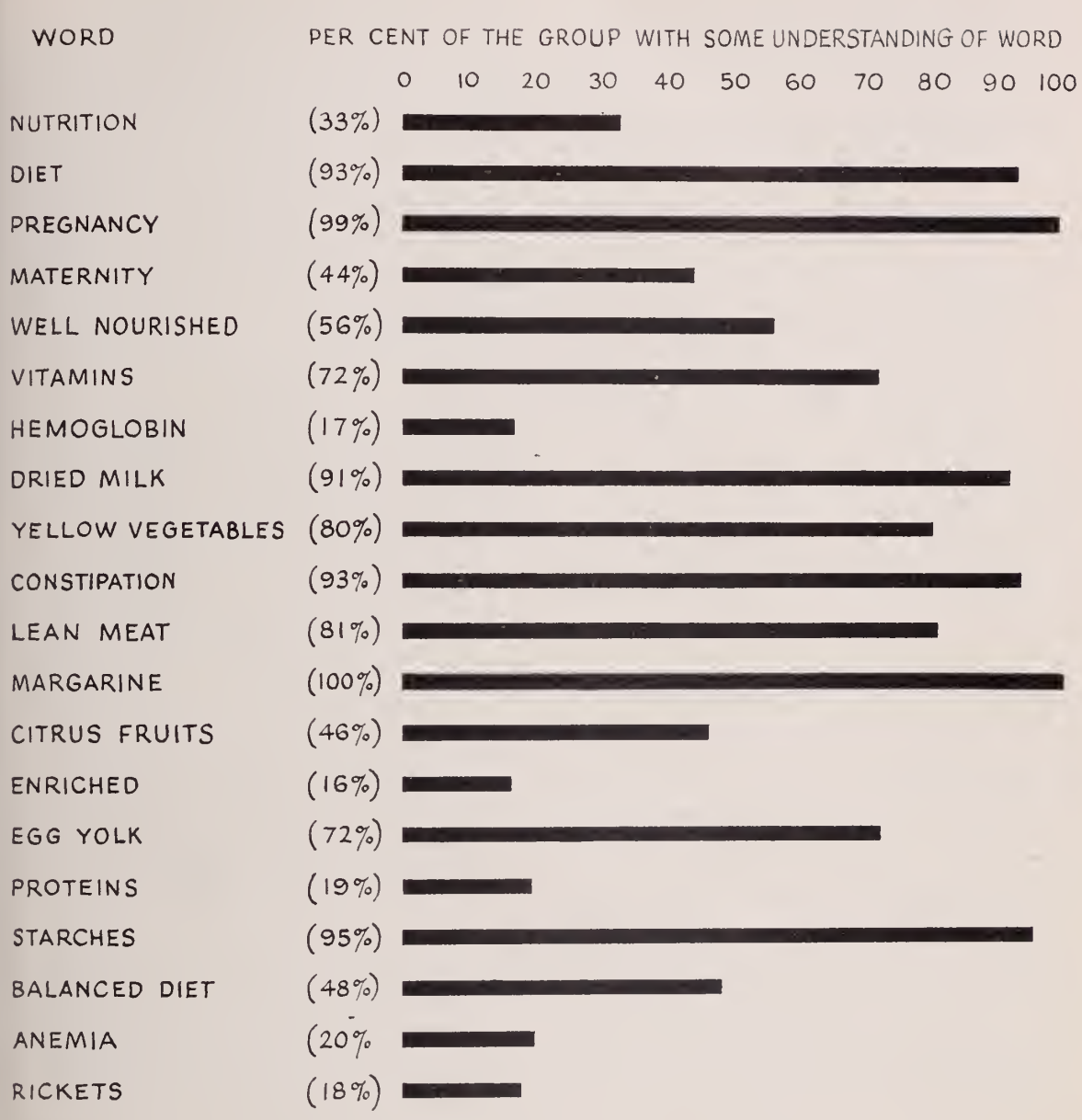


Fig. 1.—Proportion of patients with some comprehension of meaning of each word.

The 50 patients who had some high school education understood an average of 13.4 words. The remaining 50 patients with less than high school education comprehended an average of 10.4 words. For the 64 patients who had a radio and who read, the average number of words understood was 12.5. For the 17 who read but had no radio, the average number understood was 12.3. For the 15 patients who had a radio but did not read, the average number understood was only 9.5 words.

There was a noticeable tendency toward similar definitions even though at times the definition was far removed from the correct one. Some of those most commonly observed were:

1. "Margar- een" was the pronunciation understood by most of the patients. If I pronounced the word "margarine," the patients frequently asked, "Do you mean margar-*een?*"
2. "Powdered" not "dried" milk was the term most patients used.

3. Beef was seldom listed as a lean meat. Ham and bacon were named frequently.
4. "Maternity" meant a type of dress to most patients.
5. Although white potatoes were named as a starchy food, sweet potatoes were seldom mentioned in any capacity.
6. Grits was seldom named as a starchy food. Yet, grits is a frequent item on the daily diet.
7. Carrots were often named as a yellow vegetable. Further questioning revealed, however, that they were seldom eaten.
8. Anemia was almost always defined as "enema."
9. Rickets was frequently interpreted to mean a "shaky" baby.
10. Vitamins meant some sort of "pills;" seldom were they related to foods.
11. Well nourished meant a "nervous" body.

Part II. Pica Study

Shortly after the interviews for the investigation began, I discovered that many patients were eating either laundry starch or clay dirt. At that point, I added to the interview an inquiry about this habit. The entire interview was otherwise completed before the patient was asked this question. Thus good rapport had been established so that it was more likely accurate answers to such a question would be given. The question was posed in such a manner that the patient would consider it a routine question with no necessity for embarrassment if she should be eating either clay or starch. No patient was condemned for such a practice; rather, some substitute was suggested. For example, several former starch and clay eaters now engage in the practice of eating dry milk solids. Certainly this food is more nutritious than starch, though consumed in not quite the way one usually plans to introduce milk into the dietary.

Table 3 gives a breakdown of patients and their response to this part of the study.

The 34 patients admitted without hesitancy that during pregnancy they regularly ate starch, clay, or dirt. Further questioning regarding the reason for this habit revealed little except the general response, which was, "I just crave it." When the figures for this group are compared with those for the entire 100 patients, it does not appear that starch and clay eating is confined either to a rural or to an urban group. Neither does the practice seem more common among those of less schooling or less word comprehension.

Comment

As previously stated, no conclusions can be drawn from this investigation. There do seem to be certain implications, however, that make the following suggestions worthy of consideration:

1. There is a need for all medical and related personnel to review the terminology used in talking with patients. Although language may sound extremely elementary to the speaker, it is frequently confusing to the patient.
2. Literature used with patients should be explained, not merely handed out.
3. Bulletins, pamphlets and other educational material should be reviewed for the appearance of difficult words. Table 1 might serve as a check list.
4. The vocabulary deficiencies shown by this survey indicate the need for simple, concise instruction.
5. Positive statements are more effective in teaching. Inclusion of both positive and negative views often confuse the patient.
6. Some words which seem to have little meaning for this type of group are:

 Nutrition Hemoglobin Enriched
 Proteins Anemia Rickets

 Over 80 per cent of the patients in this study failed to understand these words.

Table 2. — Classification of Patients in Word Study

Number of Patients	Average Age	Schooling				From Rural Homes	Purpose of Visit			Number With Radio	Number Who Read
		None	Elementary	Some High School	College		Antepartum	Postpartum	Other		
100	25.9 years	0	50	50	0	45	85	3	12	79	80

7. Perhaps the failure to follow dietary instruction stems from not understanding the advice given. When one considers that over one fourth of these patients did not know which part of the egg was the egg yolk, the other results are not so startling.

received by 50 patients. The other one half of the group had completed or attended high school. None had attended college. An average of 11.9 words was understood from among the 20 words on the list. Only 62 of the patients understood one half or more of the group of words. Not one patient understood every word. Only 17 patients understood 80 per cent or more of the words.

Table 3. — Study of Antepartum Patients Acknowledging Pica

Number Interviewed	Starch, Clay or Dirt Eaters	Average Age	Some High School Education	Average Number of Words Understood
76	34	25.4	47	14

8. There is a real need for nutritionists to work more closely with other health personnel. Interpreting dietary needs, assisting with simple teaching technics and supplying simple reading material should be given renewed emphasis.
9. Awareness of local customs, vernacular and habits should help all interested persons to scale advice to an understandable level.
10. An occasional check to see if the patient understands what is being said might keep one in touch with the patient.
11. Further study of dirt or clay eating habits might provide interesting data. An attempt to relate physiologic needs to such habits might be of interest.

Summary

An informal survey was made among 100 patients attending public health clinics. This survey was designed to determine how many words the patients understood from among a list (table 1) of 20 words commonly used during the nursing or medical interview. The list was taken from words used in giving dietary instruction or advice.

These patients represented both rural and urban areas of Northwest Florida; 45 patients came from rural homes, the remainder from the city areas. Some elementary schooling had been

A second study was added to the survey after the investigation was begun. This study revealed that among 76 patients, 34 regularly ate either clay or laundry starch during pregnancy. These patients averaged 25.4 years of age. Their average word comprehension was 14 words whereas the average for the whole group (100 patients) was 11.9 words. Forty-seven per cent of this group had some high school training. Fifty per cent of the entire group had some high school training.

Suggestions are made for utilizing the findings of the survey.

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Dr. Ralph W. Jack of Miami, chairman of the Council of the Florida Medical Association, has announced that the medical district meetings have been scheduled for October 10, District D, Fort Lauderdale; October 11, District C, Lakeland; October 12, District B, Gainesville, and October 14, District A, Pensacola.

Recent Trends in the Treatment of Trigeminal Neuralgia

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Of all the diseases which afflict mankind, trigeminal neuralgia is one of the most painful, and until recent years it has defied all treatment. Before the advent of such definitive therapy as alcohol injection, nerve section, and trigeminal decompression, it was not at all uncommon for the sufferer to resort to suicide as a means of relief from this dread affliction.

Trigeminal neuralgia is a painful condition of the fifth cranial nerve. The disease is characterized by sudden severe lancinating pains in the forehead, cheek or jaw, depending on which of the three branches of the trigeminal nerve is involved. The pains are extremely sudden in onset, the patient feeling perfectly well at one moment and writhing in pain at the next. The pains are intermittent; they may occur at intervals of every few minutes, or there may be hours or days between attacks. The patient between attacks feels perfectly normal. The pains have been variously described as like electricity, like a severe toothache, or like a hot wire in the face; there are many other descriptions, all of which denote extreme severity of the pain. Abrupt as is the onset, equally so is the relief, the attack lasting only a few seconds.

The pain may be in one or all of the three divisions of the trigeminal nerve — ophthalmic, maxillary, or mandibular — that is, in the forehead, eye, cheek, mandible, gums or tongue. The patient during an attack will cease all activity and will make peculiar facial grimaces, so severe is the pain. Attacks may occur at any time, and may even awaken the unfortunate victim from a sound sleep. Trigger areas are often present, especially on the lips or gums, so that washing the face, shaving, brushing the teeth, eating, or even talking is avoided for fear of setting off an attack. As a result, many of the patients are dirty-faced or unshaven, and almost always are undernourished because of inability to eat for fear of setting off an attack. Although young and middle-aged persons sometimes are afflicted, the disease is much more common in older age groups, from 50 to 70, and even occasionally in persons 80 or 90 years old.

Since so little is known of the etiology, little space will be devoted to discussion of it. Systemic infection, allergy, sinuses, arthritis, tonsils and teeth have all shared the blame, and countless sinuses, tonsils, and teeth have been respectively irrigated, enucleated, and extracted in fruitless attempts to cure. Occasionally a tumor, an aneurysm, or an aberrant artery is said to be responsible.

Diagnosis

Since there are no abnormal neurologic findings, the diagnosis is made by exclusion of other diseases. Tic douloureux of the glossopharyngeal nerve is similar to that of trigeminal neuralgia except for location of pain in the throat and tonsillar area. This pain is frequently temporarily relieved by cocainization of the throat. Costen's syndrome, or temporomandibular arthritis, is to be considered. Not infrequently patients with this affliction have an incorrect bite, and the temporomandibular joint should be x-rayed. Sinus disease should be excluded. Tumors of the nasopharynx eroding the floor of the skull can cause ticlike pains, but there is anesthesia of the corresponding area and paralysis of muscles of mastication. Tumors of the cerebellopontine angle have other signs such as tinnitus, dizziness, and loss of hearing in addition to trigeminal involvement. So-called atypical facial neuralgia is a more or less constant burning or pain in the face. Usually it can be differentiated by the duration of the pain.

Read before the Florida Medical Association, Eighty-First Annual Meeting, St. Petersburg, April 4, 1955.

Treatment

Surgical treatment of trigeminal neuralgia was first put on a firm foundation by Frazier, who in 1901 performed the first successful posterior root resection. This operation has since been performed thousands of times, and with extremely good results. In the patient who is a poor surgical risk, alcohol injection of the offending nerve can be carried out, and with good results in a high percentage of cases. Peripheral avulsion of the nerve is frequently performed.

Grantham and Segerburg[1] thought that avulsion is simpler than injection, particularly if the neuralgia involves a first or second division, or both, and that alcohol injection should be reserved for the third division. In an analysis of 109 cases they found that the average relief from supraorbital and infraorbital avulsion was 33.2 months whereas that from alcohol injection was 15.5 months.

Jaeger[2] reported prompt and lasting relief in 14 cases from injection of boiling water into the gasserian ganglion. He followed these cases for seven months and stated that there was no major complication. Vitamin B_{12} has been advocated by Fields and Hoff[3] and others,[4] but in my experience this has not been satisfactory. It should be tried in patients who are a poor surgical risk, or in patients not willing to undergo alcohol injection or surgery. Inhalations of tetrachlorethylene likewise have been of little benefit in my experience.

Collard and Hargreaves[5] and Collard and Nevin[6] observed that hypalgesia confined to the face appeared several months after the use of stilbamidine in the treatment of kala-azar and blastomycosis. The mechanism of this neuropathy is not known. On the basis of these reports, Smith and Miller[7] used stilbamidine in tic douloureux. Encouraged by its effect in relieving pain in several cases, and after trial in a total of 16 cases, they[8] concluded that this is an effective and safe drug to use in this malady provided the solution is fresh and is used immediately. Excellent results were obtained in 15 cases, and a good result in 1 case over a follow-up period of four to 25 months. Almost all of the patients had previously received alcohol injection, and 3 previously had undergone posterior root neurotomy. The typical course in these patients was that they began obtaining relief in four to eight days after treatment was begun, but exacerbation of pain was noted one or two months afterwards. Gradually the number and severity of attacks decreased, and complete freedom from pain occurred from two to four months after treatment was started. Mild paresthesia appeared about the third or fourth month. One important point was that corneal reflexes were preserved in all 16 patients. Stilbamidine isethionate, 0.15 Gm., is dissolved in 200 cc. of 5 per cent glucose in distilled water, and this is given slowly intravenously. The course of treatment consists in the injection of this dose of stilbamidine daily for 14 days.

Evaluation of Therapeutic Measures

With the possible exception of stilbamidine, with which I have had no experience, and vitamin B_{12}, which I have not found particularly useful, all methods of treatment have certain disadvantages. Alcohol injection is not permanent, relief being obtained for a period of six to 18 months. Another disadvantage is that a successful block is not always obtained; Grant[9] reported a successful block in 80 per cent of the cases in his series. Since the injection is made with little or no local anesthesia, most patients in my experience are reluctant to have another injection. The injection is a trying ordeal for the patient and the surgeon alike, and one which many surgeons are anxious to avoid if possible. Sometimes extraocular palsy or facial paralysis is produced. If in injecting the third division the tip of the needle is accidentally placed through the foramen ovale and into the subarachnoid space about the gasserian ganglion, serious consequences are likely to follow. Total blindness from infiltration of alcohol about the optic nerve has been reported. Finally, a successful alcohol injection produces numbness of the face which, though this is more readily accepted than the severe pain, is still a disagreeable sensation. Avulsion of the nerve is a simple operation, and although only temporary relief of pain is afforded, in my opinion this is the procedure of choice in the patient who is a poor surgical risk. This, of course, produces facial numbness also, and relief is not permanent.

Posterior root section or partial posterior root section, though more permanent in the relief of pain, is not without its disadvantages. Peet and Schneider,[10] in reporting a series of 382 of the late Dr. Max Peet's cases at the University of Michigan in which trigeminal rhizotomy was per-

formed, related that complete relief of all types of discomfort was obtained in 29 per cent. There were paresthesias consisting of crawling and drawing sensations in 55.7 per cent, and in 30.4 per cent there was residual burning pain. Fifty-four of the 382 patients stated that they had experienced recurrence of the tic pain. In 6.5 per cent there was facial paralysis following rhizotomy. This was permanent, however, in only a few of the cases. It is noteworthy, incidentally, that in Peet's series of 689 cases, no nerve avulsions were mentioned.

It is generally accepted among neurosurgeons that facial numbness is the price a patient has to pay for relief of the pain. It remained for Taarnhoj,[11] a young Danish neurosurgeon, to prove that trigeminal neuralgia could be relieved without producing facial anesthesia. In April 1951 removal of a small epidermoid tumor from the cerebellopontine angle was followed by relief of facial pain without section of the posterior root. On the basis of this experience he postulated that small changes either in the dura or adjacent tissues perhaps of a vascular origin could narrow the channel formed by the dura to the upper sharp margin of the petrous bone, and thereby cause compression of the posterior trigeminal root. Subsequently, 10 patients were operated upon, and through a temporal intradural approach, the dura over the posterior part of the gasserian ganglion was opened widely, and divided over the posterior root to and including the edge of the tentorium.

Following the successful outcome in this small series of cases, several other reports have emerged. Gardner and Pinto[12] reported that 9 patients had been relieved by this procedure. Some of the patients had mild postoperative sensory impairment, which cleared within a few days. In their first patient a transdural approach was made. Following this operation there was a transient aphasia, and thereafter they performed the operation by an extradural approach. These authors advanced the theory that the pain in trigeminal neuralgia is due to development of an artificial synapse of the sensory root fibers where the nerve crosses the apex of the petrous bone. This artificial synapse occurs as the result of a demyelinizing process and sagging of the tentorium which accompanies advancing age. This sagging of the tentorium transfers the normal oval-shaped dural foramen into a relatively narrow slit. When this change occurs, the fibers of the sensory root, which are normally dispersed in the arachnoid sheath distended with cerebrospinal fluid, are held in contact with one another. Contact of the various nerve elements in the sensory root, together with demyelinization of some of the axis cylinders permits short circuiting of the action current which accompanies the transmission of the nervous impulse with the formation of an artificial synapse. They further theorized on the basis of studies of Granit, Laskell and Skoglund[12] and of Lewy, Groff and Grant,[12] that tic douloureux is the result of short circuiting of autonomic impulses into somatic pain fibers. Schwartz[13] was unwilling to accept the theory of compression of the root by the petrosal dura as the cause of pain. Likewise Semmes[14] did not believe that compression of the root by the dura, aberrant arteries, veins, or adhesions play a significant part, and saw no consistent abnormality in his experience in over 1,000 cases.

Love[15] reviewed the various methods of treatment of trigeminal neuralgia and summarized his experience in 39 cases in which the Taarnhoj procedure was performed. In 28 cases no trigeminal pain occurred postoperatively, and in 11 there was some trigeminal pain. One patient who had not obtained immediate relief, had posterior root resection done five days after the Taarnhoj operation. Of the remaining 10 patients who still had some trigeminal pain, he stated "that most of these" did not have real typical trigeminal neuralgia. He thought that this procedure is gratifying in most cases, and intended to continue using it in cases of true trigeminal neuralgia. The operation does not appear to be of value in atypical cases.

Love and Svien[16] reviewed 100 consecutive cases in which this operation was performed, covering a period of 21 months, and found that 58 of the patients continued to have relief. In 31 there was recurrence of the pain, and of these, 12 sought further definitive care. In 11 patients the results were indeterminate, that is, the pain in most cases was especially mild and lasted only a short period of time. In about half of the failures, pain recurred within the first month after operation, and in only 3 cases did pain recur after one year of relief. Taarnhoj[17] analyzed 43 cases of typical trigeminal neuralgia in which the patient was operated upon by this procedure. The patients were followed from three to 27 months,

and 33 had complete relief. He reported that in 27 cases of atypical trigeminal neuralgia, that is, those in which the patients suffered lightning-like pains plus constant burning pain, 15 obtained relief for one to 21 months, while in 6 cases of atypical facial pain, that is, constant burning sensation of the face, only 1 patient obtained relief. Stender[18] and Schwartz[13] reported significant relief by gangiolysis and Otenasek[19] thought that "almost anything you do to the sensory root in the trigeminal area would produce relief from pain in a significant percentage of cases."

As to technic, the standard approach is through the low temporal area. A burr hole is placed in the temporal bone and enlarged to roughly the size of a half dollar. Either the intradural or extradural approach then is used. Taarnhoj[11] originally used the intradural approach, retracted the temporal lobe, and split the dura overlying the ganglion to and including the edge of the tentorium. Love[15] used the extradural approach in the belief that with this method complications are less likely. Schwartz,[13] upon exposing and freeing the ganglion, injected it with distilled water.

In my small series of 6 cases, in which the patients have been followed from two to 12 months, the results have been gratifying. In 5 cases the trigeminal neuralgia was typical, and 1 patient had pain from carcinoma of the face. In all cases the relief has continued to date. In 2 cases there was transient paralysis of the third nerve, and in 2 cases pain in the operative area lasted for about six weeks. In no case was there subjective facial numbness postoperatively, and no abnormality of sensation could be demonstrated by gross tests. The patient with carcinoma died four months after the operation, but was asymptomatic until her death.

Admittedly, sufficient time has not elapsed to determine long range results. The pain has been relieved in a significantly high percentage of cases, and the morbidity and mortality are low enough to justify this procedure. My belief is that the advantage of leaving the patient with normal facial sensation far outweighs the disadvantages. Before one performs this procedure, the patient should be told that there is a chance that complete relief will not be obtained, but in such cases the sensory root can then be sectioned, thereby giving relief at the expense of a numb face.

Summary

The signs and symptoms of trigeminal neuralgia are briefly reviewed. Treatment is either by alcohol injection of the affected division of the trigeminal nerve or by surgery. Each form of treatment has advantages and disadvantages, and these have been discussed. The decompression operation, although it does not afford cure in as high a percentage of cases as standard posterior root section, does give relief in a significantly high percentage. It is believed, therefore, to be a worth while procedure. Perhaps its main advantage is that there is no disturbance of sensation in the face. Should pain not be relieved, sensory root section can be performed later through the same operative approach.

A series of 6 cases is reported in which this operation was successfully employed.

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(Discussion of Dr. Bird's paper on next page)

Discussion

DR. JAMES G. LYERLY, Jacksonville: I want to thank Dr. Bird for bringing this subject before you for discussion. I agree with everything that Dr. Bird has said about the treatment and management of tic douloureux. There are only some few points that I can emphasize and state in a little different way probably. In the first place, the cause of tic douloureux is not known. Of course we know that it occurs in older people in the majority of cases. Occasionally it does occur in young people. The youngest patient I have had was 9 years old. That is most unusual, and that child is a boy in his twenties now, who remains well today and is relieved of his tic pain after an operation of avulsion of the root involved. In most of the cases, however, the patients are beyond 50 and 60 years of age. So probably age has something to do with it.

Some neurosurgeons, and Dr. Dandy especially, thought that there was some anomalous vessel or vein in the cerebellopontine angle or around the posterior root that might have something to do with tic douloureux. We know that sometimes tumors in this region or pressure of a growth may cause some pain and we also know that in multiple sclerosis — I have a patient under observation and treatment right now that I expect to operate on when I go back with multiple sclerosis with tic douloureux. There are doubtless many factors involved of which we are unaware, and so we do not know what is the cause of tic douloureux.

The diagnosis is important. There are many people with pains in the face that are not tic douloureux. We hear of various treatments being used and curing major trigeminal neuralgia or tic douloureux, when I wonder whether the patient really had the major neuralgia that we call tic douloureux. Tic douloureux should be the easiest condition to diagnose. It is a severe electric-like lancinating pain brought on by a peripheral stimulus. A light touch, like touching the trigger of a gun—these areas are called trigger zones — will set off a severe explosion of pain, and usually the branch involved is the third division or the second division. Such acts as eating, chewing, talking, washing the face, and shaving initiate the pain. It is usually present only in the daytime and not at night because when the patient is asleep, he is quiet; he is not touching his face, nor moving his lips, and so does not have the pain. These other forms of neuralgia, which we call atypical neuralgias, are usually observed in the nervous neurotic type of person. They are entirely different. They are more or less constant. The pain is not limited to the face or the fifth nerve distribution, but is apt to spread to the occipital region or down the neck in areas outside of the fifth nerve distribution. So the diagnosis is important.

When it comes to the treatment, we used to read in lay journals that B_1 vitamin would cure tic douloureux, but I have never seen a case in which tic douloureux was cured by any medical drug, either B_1 vitamin or B_{12} vitamin. Now the rage seems to be B_{12} vitamin. Of these medicines I think trichlorethylene may be the best. It has been proved that inhalation of the fumes of trichlorethylene over a period of time — I will not go into the details of the dosage — will produce some anesthesia of the fifth nerve distribution in the face, and for that reason it is supposed to relieve tic douloureux in some cases. This is true probably in about 10 per cent of the cases, but it does not cure. About the only cases in which I use it are the ones that are not amenable to alcohol injection or to major operation.

As far as stilbamidine is concerned, Dr. Smith in Baltimore has been doing some work on it and read a paper before the Southern Neurosurgical Society about a year ago. He is doing some excellent work along that line, and I think we will have more information before too long. Personally, I have not used it. I do not know too much about the effects of it. It is somewhat of a toxic drug. It is supposed to have a toxic effect on the fifth nerve and produces some anesthesia over a period of time in the fifth nerve distribution. There may be other toxic effects. I know of one patient who is getting the drug after having relief from alcohol injections which I gave him, but when the pain returned, he wanted to use stilbamidine. He has been getting the drug for several months now and apparently with some good results. So far as actual relief is concerned, the surest way to relieve tic douloureux is with some form of nerve blockage, either alcohol injection, avulsion of the nerve or section of the posterior root, and now the most recent means is decompression of the gasserian ganglion and the posterior root. I still give alcohol injections. I think there are some advantages in alcohol injection. In the first place, if you are not sure of the diagnosis of true tic douloureux, you give the person an alcohol injection, and when you get complete anesthesia of that branch and relief of the pain, you are reasonably sure of the diagnosis. Another consideration is that some patients do not know whether they will like the numbness after a major operation. If you give them alcohol injections, they will see what the numbness is like. If they do not like it, the numbness will wear off in eight or nine months on the average, and when it returns of course the pain of tic douloureux may return along with it. So alcohol injection I think has a definite place.

I have employed the decompression or Taarnhoj operation for tic douloureux in several cases. I always explain to the patient the possibilities of the operation, that it has not been performed long and that statistics show so far that it relieves the pain in 80 to 90 per cent of the cases. When I explain it to the patients, they usually say, "I would rather go ahead and have the posterior root sectioned, even though I do get anesthesia of the face. I want to get rid of this pain once and for all." After all, posterior root section is the only measure that we know today that is the surest way to give permanent relief. When I go back, I expect to perform the decompression operation on the patient of whom I just spoke. I think you have to explain it to the patient; you have to sell the patient on the idea with the understanding that if the pain does recur, you can easily go into the same operative field and approach and cut the posterior root.

DR. BIRD, concluding: I thank Dr. Lyerly very much for his excellent discussion. I should like again to emphasize that in diagnosing this condition of trigeminal neuralgia, as he mentioned, it is extremely important to make a correct diagnosis. The so-called atypical facial pain is not at all like a true trigeminal neuralgia. If you have ever seen patients with a true trigeminal neuralgia, you will never forget them. They will be talking to you, and if you see them during an attack, they just suddenly freeze and then in a few seconds they resume their talking. It is extremely important to be sure of the diagnosis. Atypical facial neuralgia is hard to treat, and I do not believe that there is any adequate treatment for it. In Minnesota recently I was talking with some neurosurgeons, one of whom described a case of atypical trigeminal neuralgia in which alcohol injection had been given. This was followed by a posterior root resection, then by ablation of the cortical area which represented that side of the face, and later by a prefrontal lobotomy, and the patient is still having pain. So we do not know much about these atypical conditions, but we do know that they cannot be relieved by any form of surgery. I too believe that alcohol injection has its place. I think it is good in making the differential diagnosis and, too, it acquaints the patients with what it feels like to have a numb face. Some people will want another injection later, and others will then decide to go ahead with the surgery.

Abstracts of Medical Articles

The Surgical Treatment of Gastrojejunocolic Fistula. By Thad Moseley, M.D. Am. Surgeon 20:1086-1091 (Oct.) 1954.

A brief review of the incidence, symptoms and diagnosis of gastrojejunocolic fistula following gastric surgery is presented, and the evolution of the surgical treatment of this lesion is discussed. A plea is made for individualization of the method of surgical therapy. Prophylactic measures in gastric surgery are stressed as a means of reducing the incidence of gastrojejunocolic fistula. The salient features of 2 illustrative cases are presented.

Electrolyte Balance in Congestive Heart Failure. By David A. Newman, M.D. New York J. Med. 54:3401-3408 (Dec. 15) 1954.

At the outset, this author observes that since vigorous diuretic treatment of congestive heart failure has come into vogue, not infrequently this overenthusiastic treatment of the edema results in electrolyte disruption. He adds that whereas the congestive heart failure and edema, as such, may have remained stationary for months or even years, the therapeutically induced electrolyte disturbance often proves fatal quickly and suddenly. Following general discussion of the subject, he deals with the serum electrolyte pattern in compensated congestive heart failure, hypochloremic alkalosis, and the low salt syndrome.

In summary, Dr. Newman notes that the therapy of electrolyte imbalance is difficult and often disappointing. Too often, despite a reconstituted electrolyte pattern, the response to therapy is improved only temporarily, and the patient goes on downhill despite all efforts. He stresses that early recognition of electrolyte shifts and corrective measures started at once, before they become irreversible, are, therefore, of vital importance. He particularly emphasizes the necessity of following, by frequent laboratory checks, the electrolyte pattern of all patients on intensive or prolonged diuretic therapy. Only then can electrolyte disruption be prevented in time. Moreover, he concludes, one must refrain from too vigorous diuretic therapy, using all the available agents at the same time; one must discontinue the mercurials and evaluate the patient's electrolyte status immediately when the response to them begins to fail.

Trichomonas Vaginalis Infections; A Clinical and Experimental Study. By Carl Henry Davis, M.D. J. A. M. A. 157:126-129 (Jan. 8) 1955.

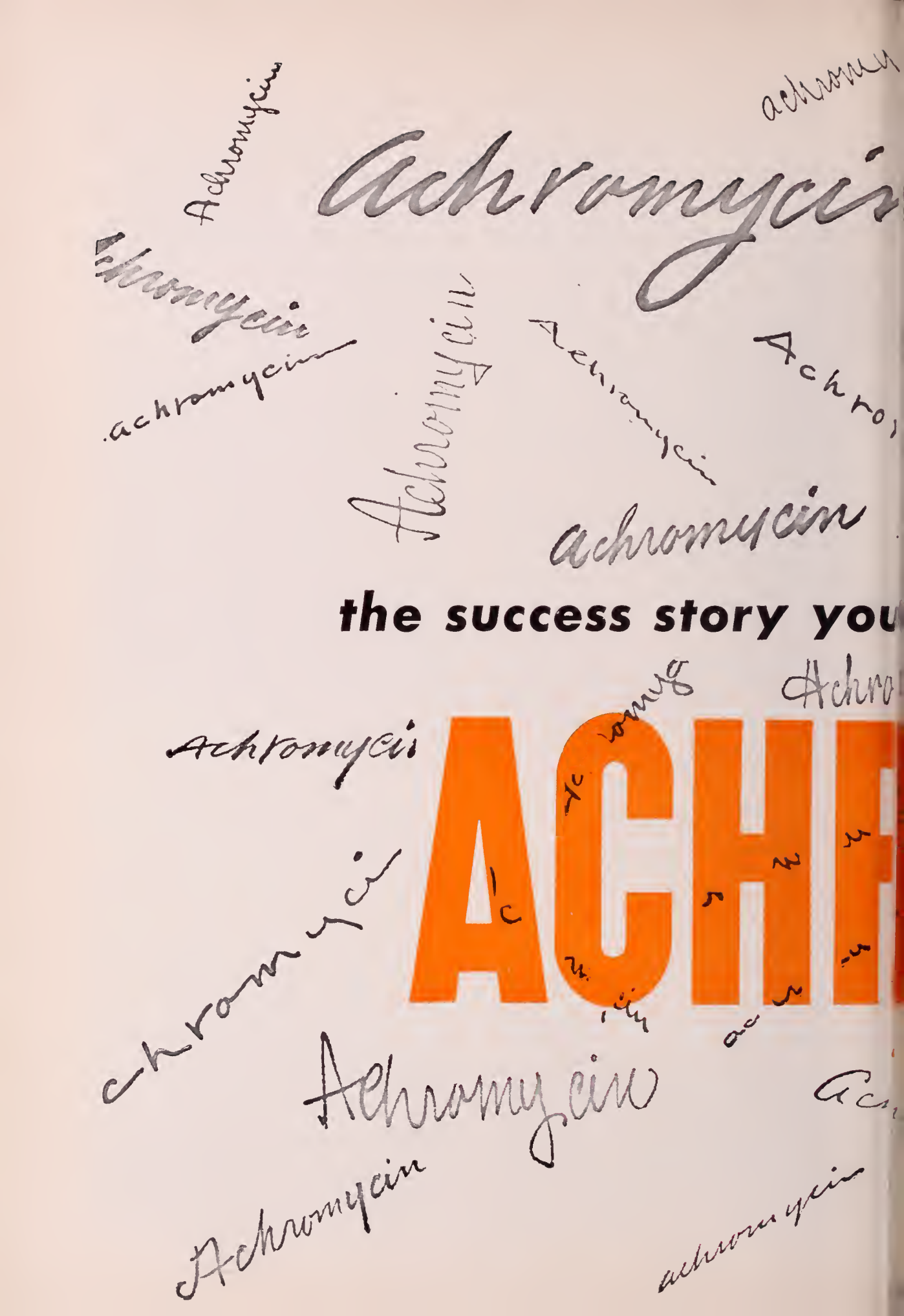
A study of large series of private and clinic patients showed trichomonads present three and one-half times and malignant cells three and one-third times oftener in clinic patients than in private patients. Women with both malignant cells and Trichomonas vaginalis infection were, on the average, 15 to 16 years younger than those with malignant cells alone. The author stated that a relationship between the conditions is suspected.

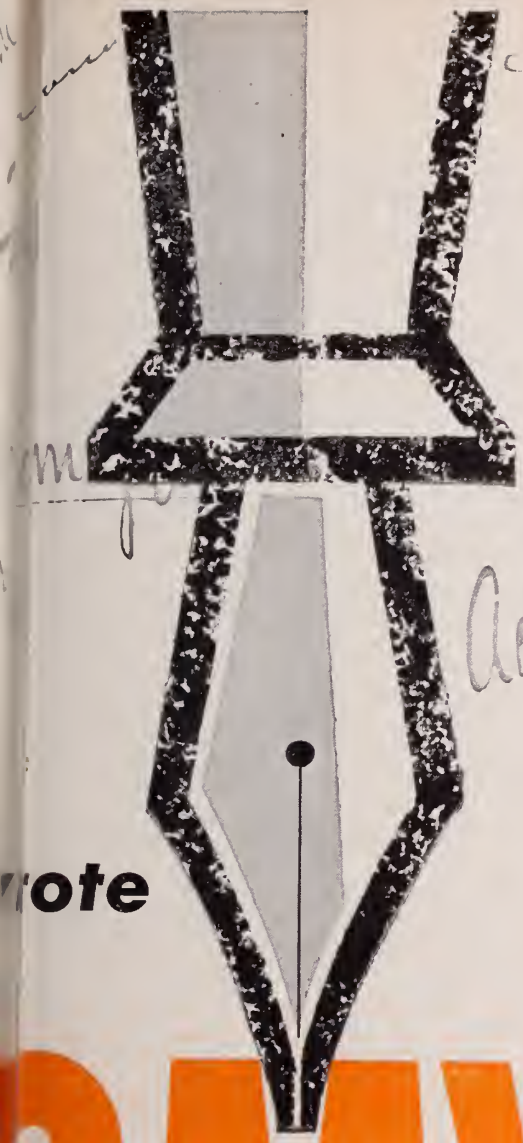
Tests of therapeutic agents in T. vaginalis infection indicated that application of sugar is unnecessary; neutral or alkaline solutions for vaginal irrigation are preferable to acid solutions; and synergism among polyoxyethylene nonyl phenol, a chelating agent, and a wetting agent makes this combination of agents (Carlendacide) an effective trichomonacide at low concentrations. Adequate office and home treatment, Dr. Davis found, can effect a cure of T. vaginalis infections, if limited to the vagina, within four weeks. He added that treatment of patients' husbands and continued treatment after cure as prophylaxis against reinfection from unknown sources are desirable.

Genital Moniliasis as a Conjugal Infection. By Morris Waisman, M.D. A. M. A. Arch. Dermat. & Syph. 70:718-722 (Dec.) 1954.

The primary objective of this report is to focus attention on the "forgotten man," the husband who is the recipient of genital dermatitis from his wife infected with Candida albicans. The author observes that simultaneously with an increased incidence of vulvovaginal moniliasis following the administration of broad-spectrum antibiotics in women, there has appeared in his practice an increased incidence of genital moniliasis in men. Sexual communicability of the infection caused by C. albicans was demonstrated in this study of 9 married male patients. In each case, the disease was acquired from the wife, in whom vulvovaginal moniliasis had developed during pregnancy or after treatment with broad-spectrum antibiotics. Clinical manifestations of genitocrural moniliasis in female and male patients are described, and treatment of the infection is outlined.

(Abstracts continued on page 124)


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(Continued from page 121)

Sigmoidouterine Fistula Complicating Diverticulitis: Report of a Case. By M. Harlan Johnston, M.D., and George M. Stubbs, M.D. Ann. Surg. 141:138-140 (Jan.) 1955.

A case of diverticulitis of the sigmoid colon with abscess and fistula formation to the uterus is presented. The diagnosis was suspected preoperatively, and a primary resection was performed.

The pathologic, roentgenologic and surgical aspects of this unusual lesion are briefly discussed.

Treatment of Asthma. By Clarence Bernstein, M.D., and S. D. Klotz, M.D. J. A. M. A. 157:811-814 (March 5) 1955.

Since asthma is a symptom rather than a diagnosis, its definitive therapy must depend on what is ultimately determined to be the cause. The prime requisite of immediate therapy is the prompt and safe procurement of an adequate airway, for which epinephrine remains the drug of choice. The authors summarize their discussion of treatment as follows: Aminophylline is dependable for bronchial relaxation, and potassium iodide is a time-proved remedy when expectorant, liquefying action is required. Oxygen may be needed temporarily. The use of morphine is still prohibited, and meperidine (Demerol) hydrochloride is to be used rarely. Safe sedatives are of great value. Corticotropin and cortisone represent important therapeutic additions, particularly in status asthmaticus. The antihistamines are useful only for "wet" asthma. Other aids include aerosols, fever therapy, Piromen, trypsin, mechanical respirators, and breathing exercises.

Psychogenic factors and psychotherapy occupy prominent positions in the diagnosis and treatment of patients with asthma. Thorough medical and allergic investigations must be made. The best treatment for patients with bronchial asthma is prevention, by treating the precursor state before asthma occurs. Effective treatment for asthma has now become polyphasic, and a wide range of modalities is employed: pharmaceutic, endocrine, antibiotic, psychologic, and physiotherapeutic. As a guide for basic orientation in this field it is not amiss to remember that at one time the union of allergen and reagin was held almost solely responsible for the entire train of events known as bronchial asthma.

Cytological Studies in Lesions of the Breast: Findings in Nipple Secretions and Aspirates from Tumors. By Richard M. Fleming, M.D. South. M. J. 48:74-78 (Jan.) 1955.

The author sets forth here his ideas as to the proper use of cytologic studies of breast secretions and aspirates, and relates his experience with this method of study. He concludes that careful study of breast secretions, cytologically, offers a valuable tool in the diagnosis of certain lesions of the breast, particularly intraductal papillomas. It is of value in the diagnosis of carcinoma of the breast only when the lesion arises from, or erodes into, a mammary duct which communicates with the terminal collecting ducts. In several cases in the series reported, the diagnosis of carcinoma of the breast was established through cytologic study of nipple secretions. Diagnosis by this method is particularly striking when made in the absence of a palpable mass.

Aspiration of masses in the breast is discussed and the indications and contraindications for its use are given. The author considers this method of diagnosis, properly applied, of considerable help in managing cystic disease of the breast. Its usefulness in the diagnosis of solid tumors of the breast also is discussed, and the indications for this procedure are enumerated.

Dr. Fleming tabulates the results he has obtained in private practice and also those in all cases examined by this method at the Miami Cancer Institute. He emphasizes that while this newer method of study is of considerable value in the management of certain lesions of the breast, it does not eliminate the necessity of histologic confirmation of positive smears. Conversely, a cytologic examination giving negative results has no value in establishing the benign nature of a lesion of the breast. Also, he advises excision of all solid masses of the breast for histologic study.

Agranulocytosis Following Diamox Therapy. By Julius R. Pearson, M.D., Charles I. Binder, M.D., and Jacob Neber, M.D. J. A. M. A. 157:339-341 (Jan. 22) 1955.

To the increasing list of medicaments capable of causing depression of the bone marrow and agranulocytosis in the peripheral blood in sensitive persons Diamox (2-acetylamino-1,3,4,-thiadiazole-5-sulfonamide) here is added, and an illustra-

tive case is presented. This toxic effect is similar in its clinical manifestations and laboratory findings to that produced by its parent substance, sulfanilamide, and all the other drugs in the category that inhibit the maturation of the myeloid cells. This is the first report of agranulocytosis arising in the course of therapy with Diamox.

The authors stress that the clinical picture of drug fever in a person receiving this oral diuretic for the treatment of chronic congestive cardiac failure should arouse the suspicion that the reaction is to the Diamox and not necessarily to a superimposed infection. This is especially important since this danger may not arise soon after this therapy is instituted and the physician may be lulled into a false sense of security by the attributes of the medicament and the improvement in the clinical cardiac picture. The toxic reaction can be overcome by simply withholding the medicament and treating the patient vigorously with antibiotic therapy with or without corticotropin or other steroid supplements.

Diagnostic Difficulties in Evaluating Pulsating Mediastinal Masses. By Charles K. Donegan, M.D., and Don C. Nouse, M.D. J. A. M. A. 157:798-801 (March 5) 1955.

Five cases are presented to illustrate the problems of pulsating mediastinal masses. In this small select group the usual clinical and roentgen examinations were inadequate for complete diagnosis. It is emphasized, however, that angiocardiographic investigations were necessary in only a small percentage of the total cases of mediastinal tumors. This series illustrates the limitation of the generalization that differential diagnosis of mediastinal tumors is easy because arterial vascular lesions pulsate, while tumors do not. The authors observe that some tumors will show definitely expansible pulsations because of close proximity to the larger arteries and also that arterial anomalous shadows may not pulsate vigorously. Critical fluoroscopic interpretation and roentgen studies by experienced observers remain the most important diagnostic procedures.

In 1 case a fluoroscopist made a diagnosis of tumor preoperatively, even though the pulsations were evident and incorrectly interpreted by another competent observer. The risk of angiocardiography was believed greater than that of surgery in this case. In 2 cases angiocardiographic studies showed mediastinal tumors that were easily excised when the previous diagnosis by fluoroscopy had been pulsating vascular lesions. All of these tumors were of cystic nature. In 2 cases angiocardiography demonstrated that the lesions were of vascular nature, and exploratory thoracotomy was avoided. It is emphasized that angiocardiographic value is the greatest when the mediastinal pulsating tumors are in the anterior and middle area. Cystic thymoma, a rare lesion in adults, was the pathologic diagnosis in 2 cases of the series.

The authors conclude that it is important to make a causative diagnosis of all pulsating mediastinal masses. A small percentage will prove to be cystic tumors, in which surgical intervention is important. The degree of pulsation of a mass is no indication of whether it is a vascular or cystic tumor.

Dehydrogenase Activity in Normal and Hyperplastic Endometrium. By Alvan G. Forbaker, M.D., Polinestor Aguilar Celi, M.D., and Sam Wesley Denham, M.D. Cancer 7:100-105 (Jan.) 1954.

In the investigation reported here the localization of sites of dehydrogenase activity in endometrium from 43 women was studied by incubating tissue blocks in neotetrazolium with succinate. The results showed:

1. Intense dehydrogenase activity in the glandular epithelium during the menstrual cycle and in hyperplasia.

2. Materially less evidence of such enzyme activity in atrophic endometrium.

No generalization with respect to the relationship between the degree of dehydrogenase activity and the stage of the menstrual cycle was permissible on the basis of the current study.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 1018, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

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Malignant Journalistic Proliferation
Witticisms of English Medical Editors

At a recent meeting of the Royal Society of Medicine in London, four distinguished medical editors left the safety of their offices to brave the dangers of the speakers' rostrum and face an audience with problems that confront medical editors. The result was a unique occasion, an enjoyable evening and a better appreciation on the part of the audience of the service which the modest "backroom boys" render the profession.

The program was opened by Dr. T. F. Fox of the Lancet in a light mood with wit described as characteristically "lupine." He stated that the founder of the Lancet in 1823 wanted the journal to publish a correct description of all important medical cases which might occur in England or on the "civilized continent," but he soon found the task was too great. More and more journal space was required. Publishers were prompt in responding to the need for journals, 5,000 having been founded during the first 30 years of medical journalism. Today medical journal proliferation has become almost malignant and has been termed "journalistic blastoma." So extensive has medical literature become that seekers for knowledge have found the cumulative quarterly index as important as the telephone directory. Dr. Fox wondered if establishment of a microfilm library and an abstract system might not do away with malignant journalistic proliferation. On mature reflection, however, he felt that reading one's journal by the fireside would be much more pleasant than digesting concentrated knowledge on cards or studying projected microfilm.

A journal encourages casual reading and allows the reader to skip. On a train, Dr. Fox had observed a skilled reader run through Lancet in 70 seconds. He characterized his journal as a general medical newspaper aimed at integrating the profession, wherein is a place for reports of cases, original work and discussion of problems relating to the profession. Thus the reader is furnished a general medical mixture which may help him to guard his patients against disease and the specialist.

Dr. A. M. Cooke of the Quarterly Journal of Medicine assured the audience that the medical editor is really the friend and not the enemy of contributors. He has a duty to be guardian of his journal's standards, but also a duty to help its

authors publish their work. He recalled that in the early days of his journal an author either had his article accepted in a tersely worded note or, which made him feel much better, had it rejected by a charming letter from William Osler. Dr. Cooke urged the members of the audience not to write unless they had something worth while to say, to be brief and clear, and to avoid slang and absurdities.

Dr. Thomson of the Practitioner stated that the editor must know what the readers want before he can wisely select material for publication. He pointed out that inasmuch as medicine is a living art as well as a science, the editor must keep an open mind and give unorthodox views a hearing since their expression sometimes stimulates new thoughts on old problems. Dr. Thomson believed that editorial comment should at times be provocative and at other times furnish a judicial summing up. The medical editor can do much to maintain the ethical code. He must be careful not to do anything that might impede progress.

Dr. Hugh Clegg of the British Medical Journal spoke of the problem created by the large volume of original articles offered for publication. Some of these were so poor that he often thought it would be fun to publish a journal for bad articles. Despite malignant proliferation he felt it is preferable to found a journal rather than to establish a professorship. If a journal is no good, it will soon die, but if a professor is bad. . . . Dr. Clegg admitted that articles in the British Medical Journal were often too learned for the middle-aged practitioner, but in the Lancet they always were so. In referring to the old controversy over whether book reviews should be signed, he recalled that Charles Dickens referred to anonymous reviewers as the "lice of literature" and agreed that any author whose book was unfavorably reviewed should have the satisfaction of knowing the reviewer's name — always on the assumption that he was not one of those difficult folk who never read books before reviewing them because it "biases one so."

Wrote Dr. John Lister in his feature column *By The London Post:*[1] "There is no doubt that the evening was a great success. In the first place it was highly entertaining, but, more important, it emphasized the service that is being rendered by . . . the medical editors. Asked where they came from, Dr. Fox answered that he often wondered where they went to, but as far as his colleagues in the Lancet office were concerned, he thought they were sent from heaven. In this mood the meeting adjourned, the editors back to their offices and the clinicians and investigators back to their desks to write more and (the editors hope) better scientific papers."

1. By the London Post, New England J. Med. 252:537-538 (March 31) 1955.

Highlights of A. M. A. 1955 Annual Meeting

Reports of the 104th Annual Meeting of the American Medical Association, held early in June, indicate that the blustery, rainy weather with which Atlantic City greeted the 31,057 registered physicians and guests failed to dampen their enthusiasm. Of 11,546 physicians registering at the convention, 2,494 were from Pennsylvania; New York was not far behind with 2,054, and New Jersey was third with 1,745. Completing the grand total were 15,912 guest registrations, 2,504 exhibitors, and 1,095 guests of exhibitors. The attendance fell short of that in San Francisco last year by nearly 12,000, but the number of physicians present was almost as large as last year. Florida was well represented with a registration of 143. There were 237 registrants from foreign countries, Canada leading with 63, then Cuba with 19, England, 14, and the Philippine Islands, 10. The Far East was represented by 28 registered physicians from seven countries, Africa by eight, Australia by five, South America by 35 from eight countries, and continental Europe also by 35 from 14 countries.

Retiring President Walter B. Martin in a statesman-like address before the House of Delegates on the opening day declared that conditions under which medicine is practiced today have changed radically, but the basic philosophy of medicine has not changed, and he added that "our obligation is to bring the best that medicine can offer to the individual patient." Incoming President Elmer Hess selected as the theme of his address before the House the nation's foremost health problem; he urged physicians to lead a campaign to "overcome the ravages of mental illness." The unanimous choice for president-elect fell upon a "country doctor," Dr. Dwight H. Murray, of Napa, Calif., who for 10 years has been a member of the Board of Trustees and for the past four years its chairman. Editorial comment in his home state paid him glowing tribute that will be echoed throughout the nation.

"No one," said one editorial appearing in the California Feature Service, "personifies more com-

pletely the average man's grateful concept of the family doctor, with his warm personal understanding of individual human needs, backed by sound training and unflagging devotion to his fellow men, than California's beloved and self-styled 'country doctor,' Dwight H. Murray of Napa.

"For more than half of his 66 years, Dr. Murray has maintained the rugged regimen of the general practitioner, ministering to all who needed him, keeping pace with the progress of his profession. Now his profession has bestowed upon Dwight H. Murray the highest honor it possesses. . . .

"It is significant, and appropriate, that the medical profession has turned to the ranks of the general practitioners for its next leader. The G.P., the family doctor, the 'country doc' — call him what you may — has not been put to pasture with his faithful old Dobbin. He is the backbone, the heart, the soul of the medical world, and despite the inevitable and necessary development of specialization, will continue to grow in importance...."

Florida delegates had a prominent role. Dr. Louis M. Orr, of Orlando, the senior delegate, was elected to the office of Vice Speaker of the House of Delegates. Elected to replace him on the Council on Medical Service was Dr. Reuben B. Chrisman Jr., of Miami. Dr. Francis T. Holland, of Tallahassee, serving his first term, introduced in the House a resolution passed by the House of Delegates of the Florida Medical Association requesting the American Medical Association to reexamine its policy concerning veterans suffering from tuberculosis of nonservice origin. The resolution was referred to the Council on Medical Service for study. Although not now a delegate, Dr. Homer L. Pearson Jr., of Miami, also ably represented Florida in his official capacity as chairman of the Judicial Council.

Among the many problems facing American medicine which came before the House for action were such major issues as osteopathy, medical ethics, intern training, hospital accreditation, and polio vaccine. The handling of the osteopathic question, culminating in the adoption of the minority report presented by one lone committeeman, offered a perfect demonstration of democratic processes at work. In consequence, ethical physicians will not be permitted to teach in osteopathic schools under present conditions. It was decreed that the dispensing of drugs and appliances by physicians is not unethical as long as there is no exploitation of the patient. A continuing study of internship approval programs and adoption of the "one-fourth rule" were recommended. A special committee will make an independent study of the present system of accreditation of hospitals, an issue which came under heavy fire. Three resolutions were passed in connection with the discussion of the Salk polio vaccine and the introduction of new methods in the treatment or prevention of disease. The first reaffirmed "confidence in the established methods of announcing new and possibly beneficial methods in the treatment and prevention of disease;" the second disapproved the purchase and distribution of the Salk vaccine by any agency of the federal government except for those unable to procure it for themselves; and the third expressed "profound gratitude to Dr. Salk and admiration for his monumental contribution to medical science."

"Medicine's Proclamation of Faith" was the theme of the inaugural program on Tuesday evening, June 7. Presented in Convention Hall before more than 5,500 physicians and their guests, with another 1,000 or more turned away, it was broadcast to the nation. Said President Hess in his inaugural address, "Unless we are willing to give of ourselves and our faith, our science will avail us little." Later he commented that the capacity crowd which jammed the vast auditorium "came to hear American medicine rededicate itself to the principles of humanitarian service and spiritual teaching and not just to watch a new president installed. . . . In Atlantic City we demonstrated to the public that we do have a heart and that we do believe in the basic philosophy of the A. M. A. — selfless dedication to mankind and a never-ending effort to improve the quality of medical care, which is already the finest that can be found anywhere in the world." Dr. Norman Vincent Peale, eminent clergyman and guest speaker on the inaugural program, pointed out that "the drawing together of medicine and religion is a step in helping man toward proper use of his God-given potentials and qualifications."

Other highlights of the convention were: Dr. Donald G. Balfour, distinguished surgeon, author and researcher, of the Mayo Clinic, received the 1955 Distinguished Service Award for his outstanding contributions to medicine and humanity. Dr. Harry D. Vickers, Little Falls, N. Y., headed a group known as "The Flying Physicians," more than 56 of whom piloted their own planes to the convention. The Scientific Exhibit was crowded

most of the time; more than 325 exhibits highlighted recent advances in all phases of medicine. One of the 40 films presented was a full color motion picture showing the actual passage of an ovum within the female reproductive system. The panel discussion on the Control of Poliomyelitis probably attracted the greatest number of physicians at one time. All of the experts were there, including Jonas E. Salk, Hart E. Van Riper, Thomas D. Dublin, Thomas Francis Jr., and Leonard A. Scheele. The Mississippi delegation presented the Board of Trustees with a gavel made from timbers of the building in which the cause and cure of pellagra were discovered.

The American Medical Education Foundation received a check for $80,000 from the Woman's Auxiliary to the American Medical Association. The A. M. A. Law Department and the Council on Medical Service were authorized to proceed with a nationwide survey of professional liability prevention and insurance programs. At the Conference of Presidents and Other Officers of State Medical Associations, Senator John W. Bricker of Ohio addressed an overflow crowd on "The Backdoor to Socialized Medicine." Senator Estes Kefauver of Tennessee spoke to the National Medical Civil Defense Conference, and his remarks pertaining to medical preparedness in case of an atomic war were widely quoted in the press.

The meeting was covered by 65 writers from the nation's leading newspapers and magazines, 29 newspapermen, nine wire service reporters, 17 magazine staff writers and 10 free lance magazine writers. The next big meeting, the 1955 Clinical Meeting, will be held in Boston, beginning on Monday, November 29, and continuing through Thursday, December 2. Next year the Annual Meeting will be held in Chicago, June 11-15, and the Clinical Meeting in Seattle, November 27-30. The 1957 Annual Meeting is scheduled for New York, June 3-7.

Registration

Total registration of Florida Medical Association members at the 1955 A. M. A. annual meeting in Atlantic City was 107. Members in attendance were:

BELLE GLADE: Wilbert O. Norville (Col.). COCOA: Thomas C. Kenaston, Charles E. Russell. CORAL GABLES: George R. Gage, James K. McShane, Frederick P. Poppe, Louis C. Skinner Jr. FERNANDINA BEACH: Henry B. Dickens Jr. FORT LAUDERDALE: Milton N. Camp, Benjamin F. Hart, Paul W. Hughes, Richard A. Mills, George T. F. Rahilly, Lees M. Schadel Jr., Charles J. Zinn. FORT PIERCE: Laurance D. Van Tilborg. HALLANDALE: Maxwell M. Hartman. HIALEAH: Stanley J. Ruzow. HOLLYWOOD: Randall W. Snow. INDIAN ROCKS: Warren J. Brown. JACKSONVILLE: Lee E. Bransford Sr., John R. Browning, Gordan H. Ira, George I. Raybin, Wilson T. Sowder, Wray J. Tomlinson. KISSIMMEE: John O. Rao. LAKELAND: Louis J. Polskin. LAKE WALES: Joseph A. Wiltshire (Col.). MIAMI: J. Ernest Ayre, Reuben B. Chrisman Jr., Francis N. Cooke, Chester Cassel, Carl H. Davis, Herbert Eichert, Raymond L. Evans, M. Jay Flipse, Francis W. Glenn, James J. Griffitts, Joseph T. Lana Jr., Morris E. Kuckku, Carlos P. Lamar, George D. Lilly, Donald F. Marion, John D. Milton, E. Sterling Nickol, Benjamin G. Oren, Raymond E. Parks, Homer L. Pearson Jr., Gerard Raap, Harold Rand, Wiley M. Sams, Ralph F. Sappenfield, Roy F. Saxon Jr., George F. Schmitt Jr., William Steinman, Richard F. Stover. MIAMI BEACH: Theodore M. Berman, Max Gratz, Irvin M. Greene, Harold S. Kaufman, Maurice Lev, Charles Lippow, Cayetano Panettiere, Paul N. Unger, S. Charles Werblow. MIAMI SHORES: Robert A. Mayer. NORTH MIAMI: Charles F. Biggane Jr. ORLANDO: A. Tayloe Gwathmey, Eugene L. Jewett, Harold W. Johnston, Duncan T. McEwan, Pleasant L. Moon, Louis M. Orr. PAHOKEE: Ernest C. Johnson Jr. PALM BEACH: David A. Newman, Walter G. Robinson. ST. AUGUSTINE: Vernon A. Lockwood. ST. PETERSBURG: William K. Barton, Elmer B. Campbell Jr., Charles K. Donegan, Abraham J. Gorday, Paul S. Herr, Robert M. Kilmark, Robert J. Needles, Joseph W. Pilkinton, Richard H. Sinden, Nathaniel C. Tomson, Abbott Y. Wilcox Jr. SANFORD: Terry Bird. SARASOTA: John M. Butcher, Thomas G. Dickinson, Joseph Halton. SEBRING: Leldon W. Martin. TAMPA: Frank S. Adamo, Chadbourne A. Andrews, Efrain C. Azmitia, Joshua C. Dickinson, Neal J. Phillips, Edward F. Shaver, Wesley W. Wilson. TALLAHASSEE: Merritt R. Clements, Francis T. Holland. WEST PALM BEACH: Ralph M. Overstreet Jr., James C. White. WINTER PARK: Ruth S. Jewett, Walter B. Johnston.

Medical District Meetings
October 10-14, 1955

1955 Tri-State Obstetric Seminar

The Florida Medical Association and the Florida State Board of Health announce the Fifth Annual Tri-State Obstetric Seminar to be held at the Daytona Plaza Hotel, Daytona Beach, on September 12, 13 and 14, 1955. An outstanding panel of nationally known figures in the fields of obstetrics and pediatrics will present papers on subjects of general interest within their respective fields and also will serve as members of a panel to answer and discuss questions submitted by those attending.

Among those who have already accepted for this year's Seminar are Dr. William J. Dieckmann, Professor of Obstetrics and Gynecology, University of Chicago, The School of Medicine; Dr. Carl P. Huber, Professor of Obstetrics and Gynecology, Indiana University School of Medicine; Dr. Samuel Wishik, Professor of Maternal and Child Health, School of Public Health, University of Pittsburgh; Dr. John Parks, Professor of Obstetrics and Gynecology, George Washington University School of Medicine.

This meeting, which is rapidly gaining wide recognition, is sponsored by the Bureaus of Maternal and Child Health of the Florida, Georgia and South Carolina State Health Departments, and the State Medical Associations of these three states. All physicians are welcome. There is no registration fee. Programs will be distributed to all physicians at a later date.

Graduate Medical Education

The Department of Medicine of the Graduate School of the University of Florida in cooperation with the Florida Medical Association and the Florida State Board of Health presented during the month of June two courses at the George Washington Hotel in Jacksonville.

Postgraduate Course in Psychiatry

The first course, on Psychiatry, was planned as a practical aid to nonpsychiatric physicians and drew an attendance of 43. The lectures were presented by Dr. Hans Lowenbach, Professor of Psychiatry, Duke University School of Medicine, Durham, N. C., Dr. Leo H. Bartemeier, Medical Director, The Seton Institute, Baltimore, and Dr. Virginia L. Clower, Douglas A. Thom Child Guidance Clinic, Cambridge, Mass. The lecturers held to the request made of them to present their subjects in a manner designed to be of benefit to the general practitioner, the internist and, in fact, any physician handling patients. They discussed the subject of child delinquency from the standpoint of the research worker and from the standpoint of the psychiatrist. Their approach indicated that a sincere effort is being made to solve this problem. They showed clearly that juvenile delinquency is not a development of modern civilization although the opportunity for increased crime and more serious consequences has been accentuated. Further, they presented the thought that psychiatry is only advanced psychology dealing with the abnormal.

The entire program, covering the psychiatric problems of patients in all age groups, was intensely practical and stimulating and proved highly rewarding to all in attendance. The success of this first course on this subject ever to be presented in Florida's graduate medical education program points up the need of physicians in general for this type of training and encourages future efforts to interest an ever increasing cross section of the profession who would welcome and put to good use this training.

In addition to the scientific sessions there were two evening meetings open to the general public. The subject discussed on Thursday evening, June 16, was "Children and Parents," and on Friday, June 17, the subject was "Drinking Can Be a Problem." The interest and attendance on the part of the public were most gratifying and encouraging. Co-sponsor for the course was the Northeast Florida Association for Mental Health.

Graduate Short Course

The Twenty-Third Annual Graduate Short Course was held the week of June 20-24. The lectures were all well presented and well received by an enthusiastic group. The total registration was 152. One of the outstanding features was the lectures presented by Dr. Herbert D. Kerman, Associate Professor of Radiology and Director, Radioisotope Laboratory, University of Louisville School of Medicine, Louisville, Ky. He made no effort simply to interpret roentgenograms; rather, he presented an advanced course for the internist and general practitioner, explaining the recent developments in his particular field. Dr. Wilburt C. Davison, Dean and Professor of Pediatrics, Duke University School of Medicine, Durham, N. C., and Dr. Eugene A. Stead Jr., Professor of Medicine, Duke University School of Medicine, both of whom are well known to most of the physicians of Florida, presented subjects of practical interest to pediatricians, general practitioners and internists

alike. In the surgical field, Dr. William F. Rienhoff Jr., Associate Professor of Surgery and Instructor of Surgical Anatomy, The Johns Hopkins University School of Medicine, Baltimore, presented his subjects entertainingly. He was frequently at variance with some of the more radical-thinking physicians of the country, but at all times was tolerant. The gynecologic lectures by Dr. Leonard Palumbo, Assistant Professor of Obstetrics and Gynecology, University of North Carolina School of Medicine, Chapel Hill, N. C., were all of practical interest and well received. The two panels, one on Medicine and one on Surgery, were well attended, and the questions indicated keen interest. It was evident that the physicians in attendance found in this type of teaching the specific information they desired.

The dinner on Wednesday evening was an innovation for the Short Course. The principal address was by Dr. J. Wayne Reitz, President of the University of Florida, who discussed at length the integration of the medical school with other graduate schools at the University as well as the plans for preparing the prospective medical student for graduate education. Dr. John S. Allen, Vice President of the University, Dr. Russell S. Poor, Provost for the J. Hillis Miller Health Center, and Dr. George T. Harrell Jr., Dean of the College of Medicine, spoke briefly. Dr. Francis H. Langley, President-Elect of the Florida Medical Association, was introduced and addressed the gathering. Rear Admiral Charles F. Behrens, District Medical Officer, Sixth Naval District, Charleston, S. C., also addressed the group briefly. Dr. Wilson T. Sowder, State Health Officer, was present representing the Florida State Board of Health.

Dr. T. Z. Cason of Jacksonville received tribute from Dr. Reitz and several other speakers as the leader who pioneered a pathway for the development of the Medical School and Health Center at the University of Florida. It was pointed out that he instituted for the Florida Medical Association the annual postgraduate short courses and has directed them throughout the 23 years they have been held. Dr. Raymond H. King, President of the Duval County Medical Society, presented Dr. Cason with a framed certificate of merit in recognition of his service to medical education across the years. Dr. Thomas H. Bates of Lake City, a member of the Association's first Committee on Medical Postgraduate Course, spoke of its activities and reviewed the early progress of the graduate medical education program.

Practical Program of Public Relations Five Major Aspects

II. Paying for Medical Care

The most important component of the medical profession's public relations is, and always will be, the trusted family physician. Today, he must be a versatile chap, no longer free to devote himself to the scientific aspects of medicine alone. He must take into consideration and be familiar with the social and economic aspects as well. The enemies of free enterprise who would regiment medicine — and mistake not, they are still around in appreciable force — see the issue for the most part as an economic one, based on the false idea that money can cure the evils that beset mankind. The physician, on the other hand, points out that the most important consideration is a high standard of medical service to the people. The eight channels through which the program of the Bureau of Public Relations of the Florida Medical Association endeavors to maintain a high standard of medical service and make it available to all the people were set forth editorially in The Journal last month in the first of this series of editorials delineating the five major aspects of this program.

The medical profession is keenly aware of the high cost of medical care. No one is more so than the individual physician. He fully realizes that the problem is a complicated one indeed, related to the entire economic pattern, and that medical fees are but a fraction of it. He appreciates, too, the opinion recently expressed by Illinois' Dr. Harlan English: "Some professional people know the price of everything and the value of nothing. Being exposed to the 'gravy of grateful hearts' might change their views on public relations, which are the sum total of our private patient relationships and cannot be measured by surveys or bought with dollars."

In its positive public relations program the Association emphasizes three constructive approaches to the problem of paying for medical care. The first is to promote friendly and frank discussion of fees and related services between physicians and patients to avoid misunderstandings and enlighten the public on costs of medical care. Hundreds of members of the Association, like their colleagues across the nation, have found that a friendly discussion of services and fees has helped to improve their doctor-patient relationships. A helpful adjunct in this particular is the A. M. A. plaque, "To All My Patients," which now greets patients

from the wall of most doctors' offices with an invitation to promote mutual understanding by freely discussing the financial situation. Many patients find it dificult to bring up the discussion of fees, and too many complain everywhere but to the doctor that medical bills are too high or not clear. If the doctor will take the initiative in putting his patients at ease in this regard, assuring them of his goodwill and sincere desire to bring them the best possible medical care, he will be making an investment in sound public relations, which is an asset in any doctor's office.

The second approach is to promote the extension and development of voluntary health insurance to meet the needs of the public in paying the costs of illness. Health insurance is good medicine because it enables the patient to help himself to health; it frees him from the added ill of worry about money while he is worrying about his physical ailments. We Americans are insurance-minded, and the family physician has a great opportunity to lead his patients into full appreciation of the value of health insurance policies to take some of the economic shock out of serious illness and injury. Voluntary health insurance places emphasis where emphasis belongs and offers a wide variety of plans to meet the needs of all. It is designed for the great majority of people who pride themselves on being able to manage their own finances so that they can provide for the usual costs of minor illnesses but for whom a serious illness or injury might become a real financial burden. The patient will be gratified to learn that his physician is interested in his health insurance plan just as he is in his health. It gives him an added sense of security, protection and well-being to know that his doctor is concerned that he have adequate, dependable coverage, and that he have full appreciation of the wide choice of coverage available to meet his needs, thanks to the privilege of living under a free enterprise system.

Promotion of medical society sponsorship of Budget for Health Plans for financing health care on a prepayment basis is the third major approach in the Association's public relations program. This practical, ethical system of paying for medical care not otherwise covered is a convenient method of financing medical care on a prepayment basis with a local bank. It provides for immediate payment of the physician for his services and, at the same time, allows the patient the financial latitude of installment type payments arranged to suit his ability to pay. This practical recognition of the installment buying habits of the American public often makes possible the granting of loans to persons of marginal income who might not be eligible for a loan under other circumstances. The patient and the physician find this plan mutually beneficial. The physicians who use it organize, maintain and control it; its nonrecourse feature protects them; they receive immediate cash payment for professional services; their accounts receivable and collection costs are reduced; they find it convenient for themselves and their staff; by employing it they help the patient to help himself and thereby promote good relations with him. The patient, on the other hand, appreciates the opportunity to arrange for the financial obligation in the privacy of his physician's office; he realizes that his physician is taking a personal interest in his problems; and he is pleased that his health needs are being met with sympathetic understanding.

The more one examines the financial aspects of medical care the more it becomes apparent that the doctor himself is the common denominator of the problem. He is, verily, the personification of public relations, whatever the approach.

Approved Substitutes for One Per Cent Silver Nitrate for Prevention of Ophthalmia Neonatorum

The Florida State Board of Health has announced the approval of two preparations to be used by physicians as substitutes for 1 per cent silver nitrate for the prevention of ophthalmia neonatorum.

The substitutes are tetracycline ophthalmic ointment 1 per cent, or equivalent, and erythromycin ophthalmic ointment 1 per cent, or equivalent. Oxytetracycline (Terramycin) and chlortetracycline (Aureomycin) are included.

This action was taken pursuant to authority vested in the State Board of Health by Chapter 383.04 Florida Statutes, which provides that a 1 per cent solution of silver nitrate or other effective prophylactic approved by the State Board of Health be instilled into the eyes of every child at birth.

It should be emphasized that these substitutes for silver nitrate are approved for use only by physicians in hospitals. Midwives and those doing home deliveries are required to use 1 per cent silver nitrate.

OTHERS ARE SAYING

Preliminary Reports?

Sir William Osler once said, "If you know a thing to be true and see it in the newspapers, begin to doubt it at once." Many of us who were educated a generation ago still cling to the words of Osler.

We are agreed that the medical profession should participate and lead in an educational program for the public. Popularity of health columns in the press and programs upon the air attest the interest of people in their lives and health. However, when it is overdone, harm results. Examples are too numerous to mention — "miracles," youth regained, sandpaper surgery, voluptuousness, "cures" of thus far incurable diseases, to mention but a few. When it comes to rare and remarkable surgery, can't we subdue publicity until the case report is reasonably complete! Otherwise we are stretching our luck too far. All patients are not going to survive and, when one doesn't, many laymen with good memories will come at us with the old salty dictum, "The operation was a success, but the patient died." We have trouble enough without making an open bid for this shot at our oft-questioned public relations.

It is not rare to note a so-called Preliminary Report in our medical journals, or a big spread in the newspapers about some medical or surgical "miracle." And then the supplemental report, or conclusion, or result is peculiarly absent. Readers know, or take for granted, what happened: somebody jumped the gun! Perhaps we would be wiser to hold our fire and then let our public have the whole story at one time with fair and equal publicity given to both positive and negative results. It would be much safer and, in the long run, would engender more respect both in and out of the profession.

—*Rocky Mountain Medical Journal*
May 1955

1955 Medical District Meetings

October 10, District D, Fort Lauderdale
October 11, District C, Lakeland
October 12, District B, Gainesville
October 14, District A, Pensacola

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Malcolm P. Tyor of Jacksonville announce the birth of a son, William Randolph, on June 2, 1955.

Dr. and Mrs. Lawrence G. Hebel of Palatka announce the birth of a daughter, Carole Nanette, on March 28, 1955.

Dr. and Mrs. Albert T. Fechtel of Jacksonville announce the birth of a son, Kenneth John, on June 19, 1955.

Dr. and Mrs. Chester Cassel of Miami announce the birth of a daughter, Claudia Amy, on May 7, 1955.

Dr. and Mrs. Leo W. Levin of Miami Beach announce the birth of a son, Albert Zachary, on May 14, 1955.

Dr. and Mrs. Sidney Storch of Jacksonville announce the birth of a daughter, Gloria Beverly, on July 5, 1955.

Marriages

Dr. Stanley J. Ruzow of Hialeah and Miss Joan Fay Lipsitz were married May 29, 1955, in Miami.

Deaths — Members

Bitzer, Emory W., Hernando	June 7, 1955
McClellan, P. T., Vero Beach	June 9, 1955

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Creese, Philip G., Tampa
DeNote, Anthony P., North Miami
Gould, Martin G., Fort Pierce
Jaffe, Morris, Miami
Martini, Taverno A., Tampa
Moomaw, David R., Jacksonville
Tobias, James B., St. Petersburg

COMPONENT SOCIETY NOTES

Lake

Dr. J. Cornall Howarth of Orlando was guest speaker at the June meeting of the Lake County Medical Society held at Howey-in-the-Hills. His subject was neurosurgery.

Marion

The Marion County Medical Society has paid 100 per cent of its state dues for 1955.

Palm Beach

Dr. Philip O. Lichtblau of West Palm Beach discussed rehabilitative surgery at the June meeting of the Palm Beach County Medical Society.

STATE NEWS ITEMS

Dr. J. Maxey Dell Jr. of Gainesville was in Santa Clara, Cuba, the latter part of June where he appeared on a panel for the discussion of the methods of cancer treatment.

Dr. A. Judson Graves of Jacksonville attended the meeting of the American Ophthalmological Society held recently at White Sulpher Springs, Va.

Dr. Morton M. Halpern of Miami was principal speaker at an early summer meeting of the Masons Southwest Lodge and Emanuel Chapter of Eastern Star held in that city.

Dr. Russell B. Carson of Fort Lauderdale was in Los Angeles recently where he attended the meeting of the American Urological Association.

Drs. John B. Ross and Thad Moseley of Jacksonville were guest speakers at the June meeting of the Duval County Chapter of the Florida Society of Medical Technologists.

Dr. William D. Cawthon of DeFuniak Springs attended the recent meeting of the American College of Cardiology held at New York City.

Dr. V. Marklin Johnson of West Palm Beach discussed "Laboratory Procedures in Differential Diagnosis in Jaundice" at the May meeting of the Palm Beach County Chapter of the Florida Society of Medical Technologists.

"Tensions in Family Living" was the subject of an address delivered by Dr. Merton L. Ekwall of Jacksonville in the family life series of programs held at the Jacksonville YWCA. The June meeting was the concluding session.

Dr. William Y. Sayad of West Palm Beach returned to his native country Persia the latter part of May where he was scheduled to dedicate a hospital. This was Dr. Sayad's first visit to Persia since he left there for medical study in America.

Dr. Paul W. Hughes of Fort Lauderdale was principal speaker at the final meeting for the school year of the Dania P-TA. His subject was the Salk vaccine.

Dr. Karl T. Humes of Bushnell was principal speaker at the May meeting of the Kiwanis Club there. His subject was the Salk vaccine and the RH factor.

Dr. Louis E. Pohlman of Orlando became president of the Florida Association of Blood Banks during the annual meeting held recently at St. Petersburg.

Dr. William K. Barton of St. Petersburg addressed the Boca Ciega Kiwanis Club on "From a Surgeon's Point of View" at the regular monthly meeting held the latter part of May.

Dr. Frank M. Hall of Gainesville has been elected president of the Southern Branch of the American Public Health Association.

Dr. Frederic H. Wood of Bradenton attended the 50th annual meeting of the American Urological Association held recently at Los Angeles.

Dr. Edward R. Smith of Jacksonville was a member of the panel for the discussion of "Polio Vaccine" at the recent meeting of District Two, Florida State Nurses Association, held at Jacksonville.

Dr. William M. Bevis has returned to Lakeland after attending the American Psychiatric Association meeting held at Atlantic City.

Dr. John J. Meli of Naples was principal speaker at a regular meeting of the Naples Rotary Club the first part of June. Speaking on the subject "Medicine in Naples," he delivered one of a series of vocational addresses being sponsored by the Club.

Dr. Leigh F. Robinson of Fort Lauderdale has been elected president of the Broward County Heart Association.

Dr. Sherman B. Forbes of Tampa has returned from White Sulphur Springs, Va., where he attended the meeting of the American Ophthalmological Society.

Dr. Arnold S. Anderson of St. Petersburg is

PRO-BANTHĪNE FOR ANTICHOLINERGIC ACTION



Abnormal Motility as the Cause of Ulcer Pain

Until recently the general opinion was held that ulcer pain was primarily caused by the presence of hydrochloric acid on the surface of the ulcer.

Present investigations[1,2] on the relationship of acidity and muscular activity to ulcer pain have led to the following concept of its etiologic factor:

"... abnormal motility[2] is the fundamental mechanism through which ulcer pain is produced. For the production and perception of ulcer pain there must be, one, a stimulus, HCl or others less well understood; two, an intact motor nerve supply to the stomach and duodenum; three, altered gastro-duodenal motility; and four, an intact sensory pathway to the cerebral cortex."

Pro-Banthīne® has been demonstrated consistently to reduce hypermotility of the stomach and intestinal tract and in most instances also to reduce gastric acidity. Dramatic remissions[1] in peptic ulcer have followed Pro-Banthine therapy. These remissions (or possible cures) were established not only on the basis of the disappearance of pain and increased subjective well-being but also on roentgenologic evidence.

Pro-Banthine Bromide (Beta-diisopropylaminoethyl xanthene-9-carboxylate methobromide, brand of propantheline bromide) has other fields of usefulness, particularly in those in which vagotonia or parasympathotonia is present. These conditions include hypermotility of the large and small bowel, certain forms of pylorospasm, pancreatitis and ureteral and bladder spasm.

1. Schwartz, I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: A Clinical Evaluation of a New Anticholinergic Drug, Pro-Banthine, Gastroenterology *25*:416 (Nov.) 1953.

2. Ruffin, J. M.; Baylin, G. J.; Legerton, C. W., Jr., and Texter, E. C., Jr.: Mechanism of Pain in Peptic Ulcer, Gastroenterology *23*:252 (Feb.) 1953.

SEARLE

serving as governor in Florida for the American College of Chest Physicians.

Dr. Harold H. Fox has announced removal of his office from 420 Lincoln Road, Miami Beach, to 2222 S. W. 22nd Street, Miami.

The Woman's Auxiliary to the Florida Medical Association is being congratulated on a number of awards and first places for activities of the state organization and its county auxiliaries the past year. The awards and first places were announced at the annual meeting of the Woman's Auxiliary to the American Medical Association held June 6-10 at Atlantic City.

Four awards were presented for activities in connection with the magazine "Todays Health." Two others were for contributions to the American Medical Educational Foundation. The first places were for an increase in Auxiliary membership and a showing of the nurse recruitment exhibit.

All county auxiliaries were outranked by Dade which was responsible for the winning of four awards.

Approved Substitutes for One Per Cent Silver Nitrate for Prevention of Ophthalmia Neonatorum

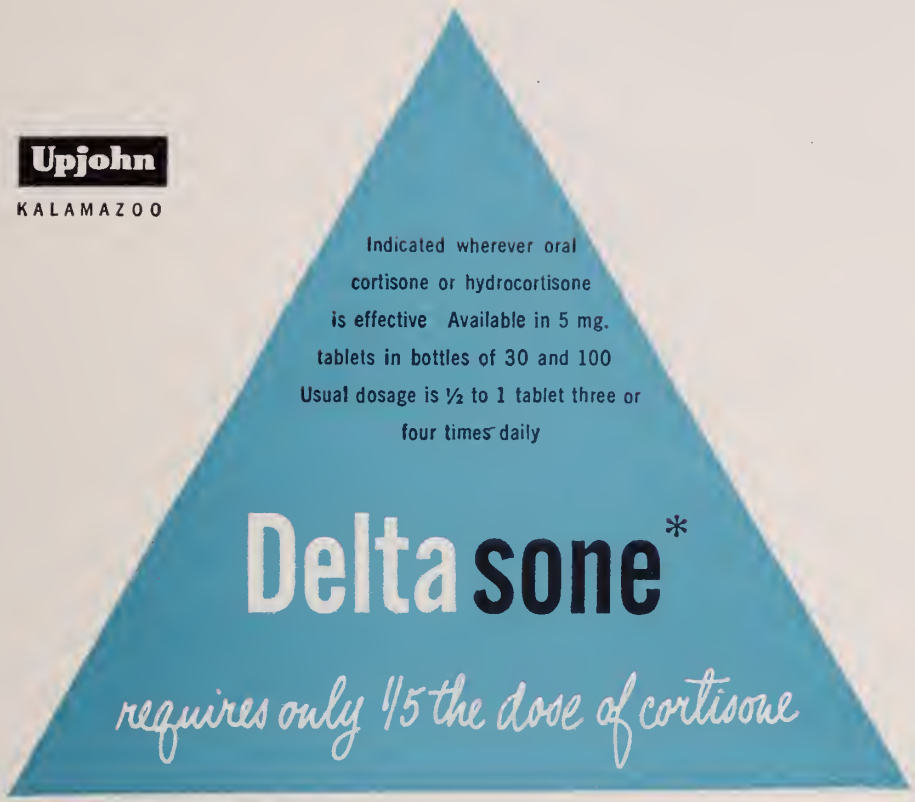
The Florida State Board of Health has announced the approval of two preparations to be used by physicians as substitutes for 1 per cent silver nitrate for the prevention of ophthalmia neonatorum.

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Dr. G. Frederick Oetjen of Jacksonville has returned from Geneva, Switzerland, where he attended the recent meeting of the International College of Surgeons.

Dr. Karl R. Rolls of Sarasota was guest speaker at services of the Laurel Street Adventist Church of that city late in June.

Drs. James L. Borland and Donald P. White Jr. of Jacksonville attended the meetings of the American Gastroenterological Association and the American Gastroscopic Society held in Atlantic City.

Drs. Ray O. Edwards Jr., James C. Lanier and William W. Waring of Jacksonville have returned from Quebec where they attended the annual meeting of the American Pediatric Society.

Dr. Mark E. Adams of Raiford has been named a trustee of the newly formed Florida Council on Aging.

Dr. Walker Stamps of Jacksonville visited various clinics throughout Europe during a trip in June.

Drs. John D. Milton and Franz H. Stewart of Miami have been honored by the University of Miami School of Medicine for "service rendered as pro-tem department heads for the school year 1954-55." Each has been presented a scroll for his meritorious service.

Dr. A. Judson Graves of Jacksonville was principal speaker at the regular meeting of the Exchange Club of Jacksonville late in June. His subject was cancer.

Dr. Turner Z. Cason of Jacksonville was presented with a Certificate of Merit in recognition of his service to medical education at the dinner June 20 during the Medical Postgraduate Short Course held at Jacksonville. Making the presentation was Dr. Raymond H. King of Jacksonville, president of the Duval County Medical Society.

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Dr. William E. Lowe of Miami entered medical service with the U. S. Army on May 7, 1955, with the rank of major.

Dr. Arthur J. Butt of Pensacola was guest speaker at the biannual meeting of the International Congress of Urinary Lithiasis held at Evian, France. The subject of his paper was "Newer Concepts Concerning Pathogenesis of Renal Lithiasis."

Dr. Federico A. Smith of Miami entered medical service with the U. S. Air Force on June 5, 1955, with the rank of major.

Dr. George S. Palmer of Tallahassee has been appointed to the State Board of Medical Examiners. He succeeds Dr. Irving L. Alberts of Miami Beach whose term has expired.

Medical Officers Returned

Dr. Horace M. Anderson, who entered military service on April 18, 1953, was released from active duty on April 30, 1955 with the rank of captain, U. S. Army Reserve. His address is 1535 San Marco Blvd., Jacksonville.

Dr. Edward E. Cava, who entered military service on June 7, 1953, was released from active duty on June 6, 1955 with the rank of captain, U. S. Air Force. His address is Mayo Clinic, Rochester, Minn.

Dr. H. Clinton Davis, who entered military service in July, 1953, was released from active duty June 30, 1955. He was chief of general surgery at the U. S. Army Hospital at Camp Gordon, Ga. His address is 1242 duPont Building, Miami.

Dr. Joseph D. Foley, who entered military service on May 4, 1953, was released from active duty May 3, 1955, with the rank of captain, U. S. Air Force. His address is 2549 Park St., Jacksonville.

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OBITUARIES

Gordon Barclay Taylor

Dr. Gordon Barclay Taylor of St. Petersburg died in a hospital in that city on March 15, 1955, after a lingering illness. He was 49 years of age.

Born in Utica, N. Y., in 1905, Dr. Taylor received his medical education in his native state. He was graduated from the University of Rochester School of Medicine in 1931. Upon completion of internships at Lakeside Hospital, Cleveland, Ohio, Strong Memorial Hospital, Rochester, N. Y., and King's County Hospital, Brooklyn, N. Y., he engaged in the practice of medicine in Utica. During World War II, he served in the Army Medical Corps as chief of the dermatology section at Camp Shelby, Miss., and Fort Benning, Ga., with the rank of major.

After his discharge from military service, Dr. Taylor located in St. Petersburg in 1947, limiting his practice to dermatology. A fine sportsman, he was keenly interested in amateur competitive sports, in which his children excelled. He was a member of St. Peter's Episcopal Church.

Dr. Taylor was a member of the Pinellas County Medical Society, and for seven years had been a member of the Florida Medical Association. He also held membership in the American Medical Association and was a diplomate of the American Board of Dermatology and Syphilology.

Surviving are the widow, Mrs. Dorothy McCormick Taylor; two daughters, Ann Barclay Taylor, and Dorothy Widdifield Taylor; a son, Robert McCormick Taylor; his mother, Mrs. John J. Taylor, all of St. Petersburg; one brother, Robert B. Taylor, of New York, N. Y., and three nephews.

Alice Robinson Miller

Dr. Alice Robinson Miller of West Palm Beach died at the home of her daughter, Mrs. J. W. Aylward, in Silver Springs on May 2, 1955. She was 87 years of age and had been in poor health for a number of years. Interment took place at Allegheny Cemetery, Pittsburgh, Pa.

(Continued on page 143)

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Bumbalo, T. S., Gustina, F. J., and Oleksiak, R. E.: J. Pediat. 44:386, 1954.

White, R. H. R., and Standen, O. D.: Brit. M. J. 2:755, 1953.

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Brown, H. W.: J. Pediat. 45:419, 1954.

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(Continued from page 141)

A native of Michigan, Dr. Miller was born in Grand Haven in 1868 and received her early schooling there. She attended Smith College, intending to pursue a course in art. Later, she elected to become a physician and received her medical training at the Woman's Medical College of Pennsylvania, where she was awarded the degree of Doctor of Medicine in 1898. She then traveled abroad and studied with famous physicians in Vienna and Berlin.

Dr. Miller first visited Florida in 1912, coming to West Palm Beach from Newcastle, Pa., following the death of her husband, Dr. William Gray Miller. In 1914, at the suggestion of her father, the Rev. Daniel Henry Evans of Youngstown, Ohio, also a winter visitor there, she decided to enter the practice of medicine in that city. She received her Florida license in 1915 and engaged in her specialty of ophthalmology and otolaryngology. The fifth doctor to establish a practice in West Palm Beach, she was the first woman to practice there and one of the first women to be granted a license to practice in this state.

One of the oldest residents of the West Palm Beach area, Dr. Miller was likewise one of its best and most enthusiastic citizens. She was a charter member of the local Business and Professional Women's Club, which honored her at a dinner when she retired from practice in 1949 after serving as a physician for 51 years. She was a member of Holy Trinity Episcopal Church in West Palm Beach.

This distinguished pioneer physician rendered service in three wars beginning with the Spanish-American War, and in West Palm Beach became the first president of the W. A. Compton Camp, USWV, Auxiliary in 1923.

Dr. Miller was the oldest member and one of the founders of the Palm Beach County Medical Society, in which she held a life membership. She became a member of the Florida Medical Association in 1921 and had held honorary status for five years. She also held membership in the American Medical Association. The American Academy of Ophthalmology and Otolaryngology honored her with a life membership, as did also the alumni association of her alma mater in Philadelphia.

Surviving, in addition to her daughter, Mrs. Aylward, the former Miss Laura Alice Miller, is one brother, George Evans, of Duxbury, Mass.

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Effect of Florida Sun Shown in Atlantic City

The Nor'Easter blew hard for three days out of the five given over to the convention of the AMA and its Auxiliary but around Auxiliary headquarters constant reminders of the Florida sun took away the gloom and made people think longingly of our sunny south. Outside the wind howled, the rain blustered and the board walk was deserted but in Haddon Hall Hotel Florida took one award after another, placing the thoughts of all on our fine weather rather than on the storm outside.

It all began on a sunny, peaceful day, Monday, June 6. At the Todays Health Workshop, presided over by the national chairman, Mrs. Richard F. Stover of Miami, the time to give contest prizes in Todays Health came and Mr. Robert Enlow, circulation director, began to call off the winners. States came first and when Florida, a member of Group III states (from 1,000 to 2,000 members) won the prize for highest percentage in that group, it started the long list of awards won by Florida. This first one was for $40 and was accepted by Mrs. Merritt R. Clements of Tallahassee for the 1954-55 chairman, Mrs. T. Bert Fletcher Jr. At

(Continued on page 150)

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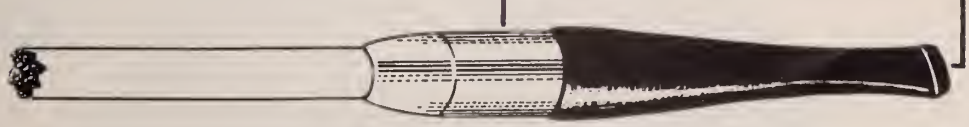
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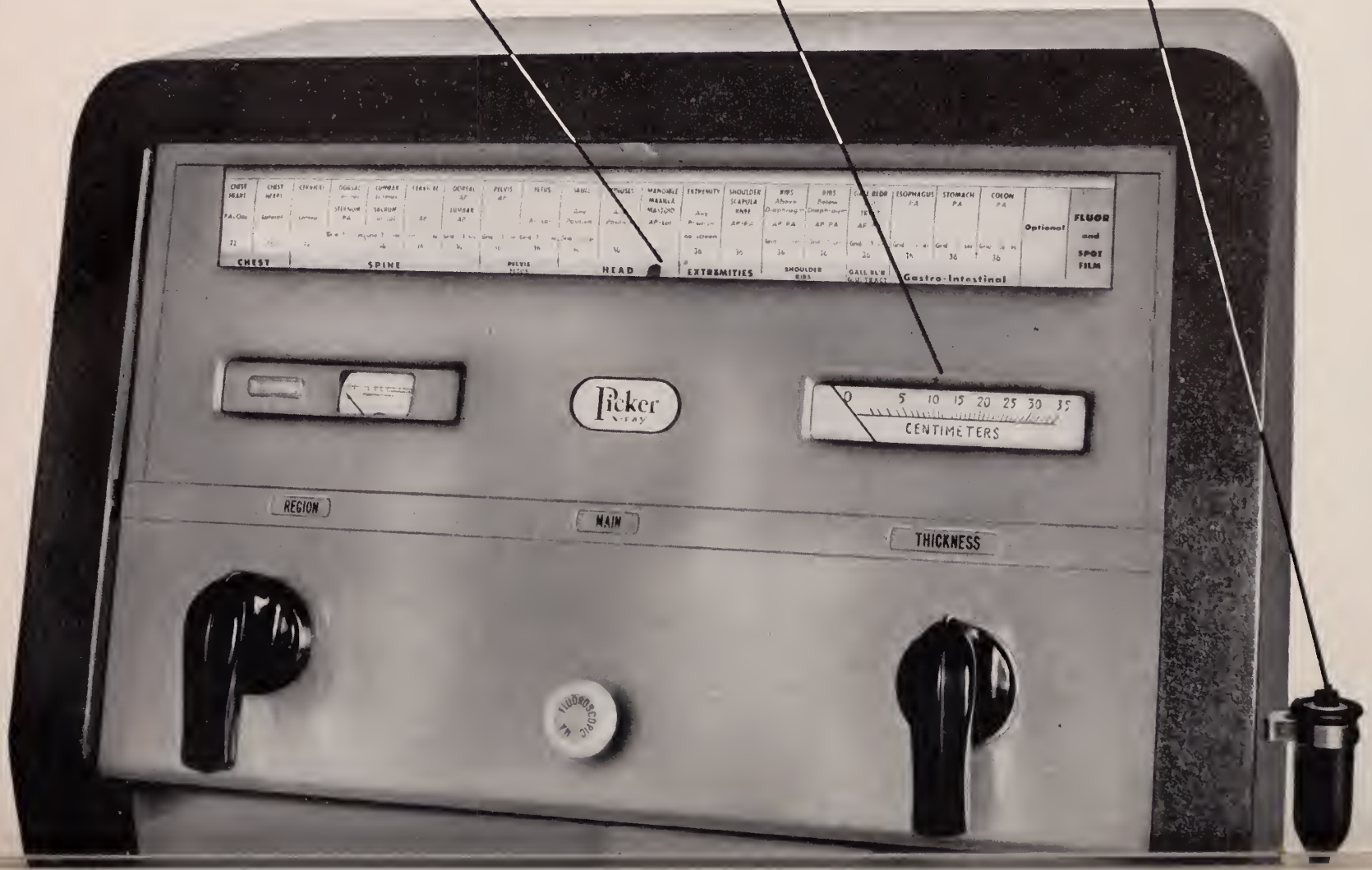
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(Continued from page 146)

the same time it was announced that Florida was the first state to ever go over 200 per cent of her quota with 207 per cent for her April 30 figure.

Next came the naming of the prize winners from the county auxiliaries and when Group IV was called (county auxiliaries with over 100 members) Dade County Auxiliary took the $40 first prize with Mrs. Frederick P. Poppe of Coral Gables accepting the check. Then came a surprise — not even known to the national chairman — a sweepstakes prize of $50 for the county auxiliary selling the most subscriptions and Mrs. Reuben B. Chrisman Jr., of Miami, walked up and accepted the check for Dade County Auxiliary once again. By this time, word had begun to be chatted about that Florida and her county auxiliaries were in for lots of awards and mentions at this convention. This proved to be true. The organization report on Tuesday showed that increase in membership in Florida was 19 per cent or 9 per cent above what had been asked by national and we believe this was the highest increase of any state. It was evident that this was just an indication of what was to come.

At the luncheon honoring the national president and president-elect on Wednesday, prizes were given for those having more than $1,000 contribution to AMEF and Mrs. Richard F. Stover received the award for Dade county which had gone over in the amount of $1,050. Preceding this, Florida won an award in AMEF for over one dollar per member ($1.42 in fact), and at the same meeting Dade county received the award for the greatest number of subscriptions as gifts under Operation Chrismas of Todays Health.

In all other activities, Florida could be proud and pleased with the report and the places it had taken, including having been the first state to show the nurse recruitment exhibit made by the AMA Auxiliary. Mrs. Samuel M. Lombardo of Jacksonville appeared on the Public Relations Panel Round Table telling about the Health Insurance Pamphlets developed in Florida and she also gave the report for Florida to the convention, having written it in poetry.

Mrs. Richard F. Stover will act during the 1955-56 year as Mental Health Chairman for the National Auxiliary.

The firsts and awards won by Florida totaled eight, a goodly number and more than any other state accumulated. We can indeed be proud and happy and go on to greater heights during this 1955-56 year.

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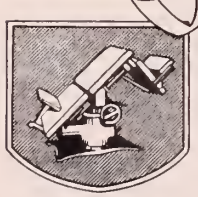
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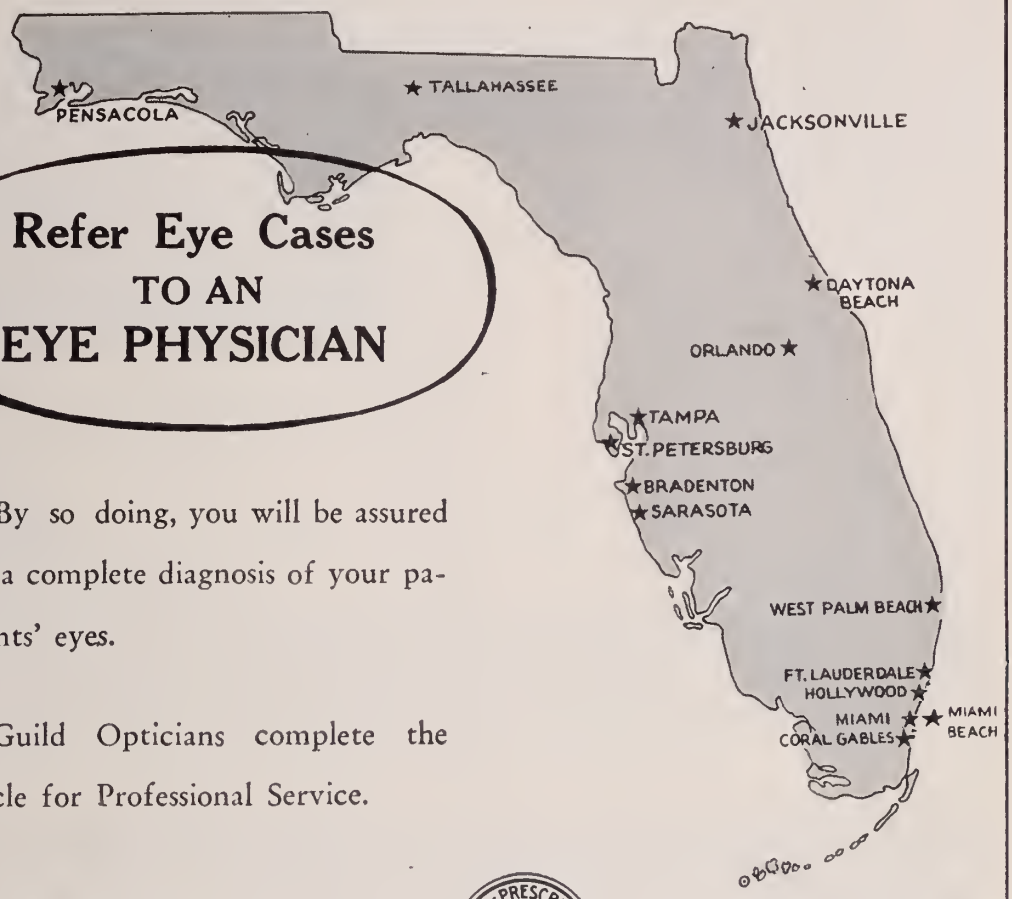
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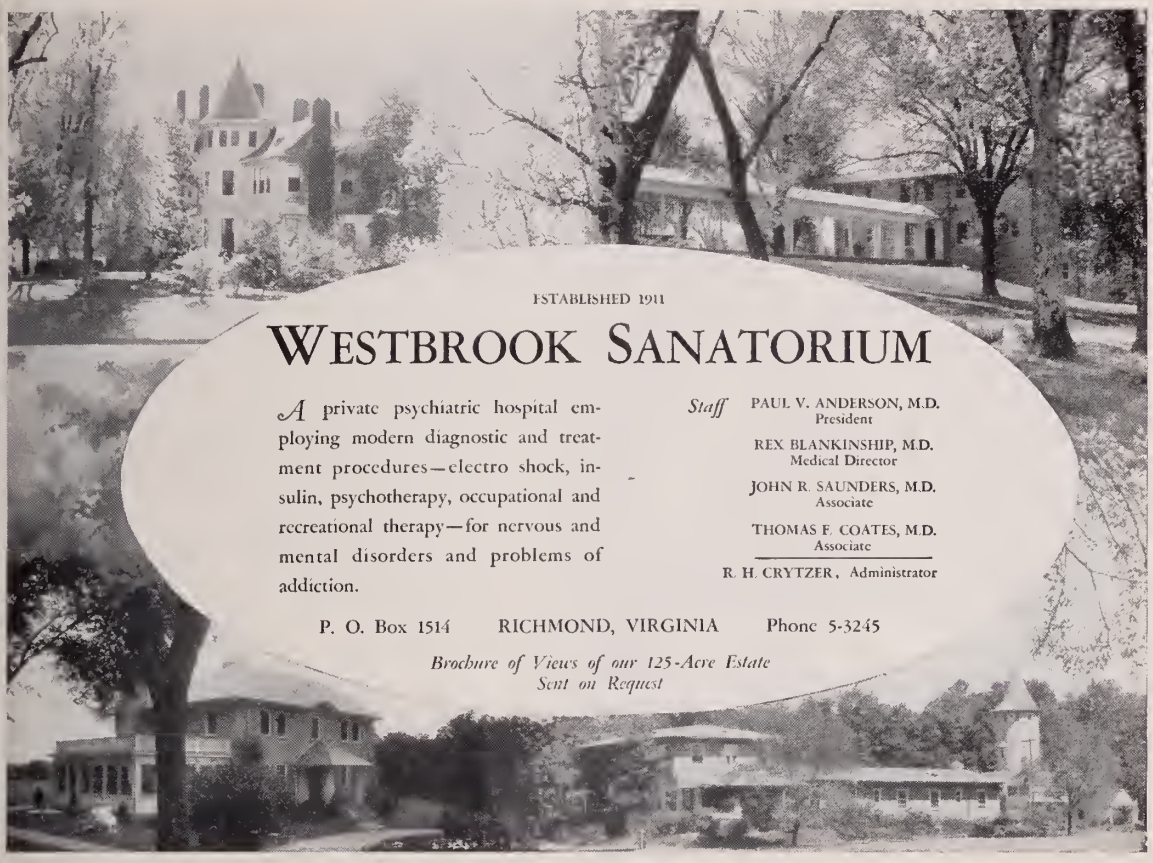
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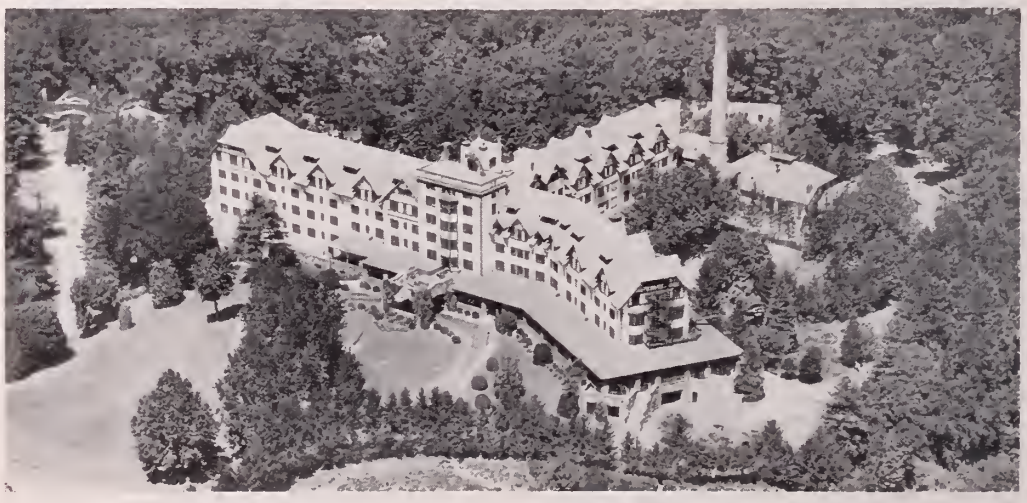
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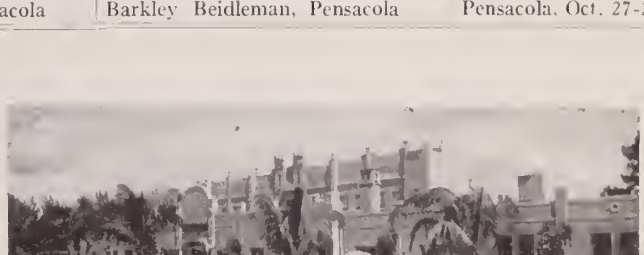
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ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Medical Association	John D. Milton, Miami	Samuel M. Day, Jacksonville	Miami Beach, May 13-16, '56
Medical Districts	Ralph W. Jack, Miami	Council Chairman	
hwest	William P. Hixon, Pensacola	Walter J. Baker, Foley	Pensacola, Oct. 14, '55
heast	Henry J. Babers Jr., Gainesville	Charles L. Park Sr., Sanford	Gainesville, Oct. 12, '55
hwest	C. Frank Chunn, Tampa	James R. Boulware Jr., Lakeland	Lakeland, Oct. 11, '55
heast	James R. Sory, West Palm Beach	Ralph S. Sappenfield, Miami	Fort Lauderdale, Oct. 10, '55
pecialty Societies			
of General Practice	Frank T. Linz, Tampa	James B. Hodge Jr., Tampa	Daytona Beach, Oct. 22-23, '55
ociety	W. Ambrose McGee, W. P. Bch.	Norris M. Beasley, Ft. Lauderdale	
ologists, Soc. of	Wayland T. Coppedge Jr., Jax	William H. Houston, Jacksonville	
s., Am. Coll., Fla. Chap.	Hawley H. Seiler, Tampa	William L. Potts, Lantana	
d Syph., Assn. of	Joseph L. Hundley, Orlando	Kenneth J. Weiler, St. Petersburg	
fficers' Society	Clarence L. Brumback, W. P. Bch.	Lorenzo L. Parks, Jacksonville	
and Railway Surgeons	Frank L. Fort, Jacksonville	John H. Mitchell, Jacksonville	
y & Psychiatry	Edward H. Williams, Miami	J. Robert Campbell, Tampa	
Gynec. Society	J. Champneys Taylor, J'sonville	Reuben B. Chrisman Jr., Miami	
& Otol., Soc. of	Charles W. Boyd, Jacksonville	Kenneth S. Whitmer, Miami	
ic Society	Edward W. Cullipher, Miami	Robert P. Keiser, Coral Gables	
sts, Society of	Millard B. White, Sarasota	Wray D. Storey, Tampa	
Society	Lewis T. Corum, Tampa	Joel V. McCall Jr., Daytona Beach	Ft. Lauderdale, Nov. 3-5, '55
ic Society	Thomas F. Nelson, Tampa	George Williams Jr., Miami	
ical Society	Hugh G. Reaves, Sarasota	Donald H. Gahagen, Ft. Lauderdale	
Am. Coll., Fla. Chapter	Joseph S. Stewart, Miami	C. Frank Chunn, Tampa	
l Society	David W. Goddard, Daytona Bch.	W. Dotson Wells, Fort Lauderdale	
cience Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, Nov. 5, '55
Banks, Association	Louis E. Pohlman, Orlando	Mrs. Estelle Lieberman, W. P. Bch.	
ross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	St. Petersburg, Dec. 6, '55
hield of Florida, Inc.	Russell B. Carson, Ft. Lauderdale	John T. Stage, Jacksonville	
Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	Miami Beach, May 13, '56
Diabetes Assn.	Sidney Davidson, Lake Worth	Edward R. Smith, Jacksonville	Daytona Beach, Oct. 20-21, '55
Society, State	T. A. Price, D.D.S., Miami	W. A. Buhner, D.D.S., Daytona Bch.	Miami Beach, May 28-30 '56
Association	Victor H. Kugel, Miami Beach	Edwin P. Preston, Miami	
al Association	Mr. Pat N. Groner, Pensacola	Mr. Steve F. McCrimmon, C. Gbls.	St. Petersburg, Nov. 16-18, '55
l Examining Board	Morris B. Seltzer, Daytona Bch.	Homer L. Pearson Jr., Miami	Miami Beach, Nov. 20-22, '55
l Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
Anesthetists, Fla. Assn.	Miss Dorothy Jackson, C. Gables	Mrs. Lulla F. Bryan, Miami	St. Petersburg, Dec. 6-8, '55
Association, State	Martha Wolfe R.N., Coral Gables	Agnes Anderson, R.N., Orlando	Daytona Beach, Nov. 28-30, '55
aceutical Assoc., State	Miss Frances Walpole, Sarasota	Mr. R. Q. Richards, Ft. Myers	
Health Association	Mr. J. A. Mulrennan, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Daytona Beach, Oct. 20-22, '55
u Society	Harold W. Johnston, Orlando	Howard M. DuBose, Lakeland	
ulosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mr. Ernest L. Abel, W. Palm Beach	
n's Auxiliary	Mrs. Samuel Lombardo, J'sonville	Mrs. Leffie M. Carlton Jr., Tampa	Miami Beach, May 13-16, '56
Medical Association	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Chicago, June 11-15, '56
Clinical Session	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Boston, Nov. 29-Dec. 2, '55
Medical Association	Robt. L. Sanders, Memphis, Tenn.	Mr. V. O. Foster, Birmingham	Houston, Nov. 14-17, '55
Medical Association	F. L. Chenault, Decatur	Douglas L. Cannon, Montgomery	Birmingham, Apr. 19-21, '56
Medical Assn. of	H. Dawson Allen Jr., Milledgeville	David Henry Poer, Atlanta	Atlanta, May 13-16, '56
spital Conference	Mr. D. O. McClusky Jr. Tuscaloosa, Ala.	Mr. Pat Groner, Pensacola	Miami Beach, Apr. 18-20, '56
tern Allergy Assn.	Ben Miller, Columbia, S. C.	Kath. B. MacInnis, Columbia, S.C.	Charlotte, N. C., Oct. '56
tern, Am. Urological Assn.	Sidney Smith, Raleigh, N. C.	Robert F. Sharp, New Orleans	Hollywood, Mar. 25-29, '56
tern Surgical Congress	Donald S. Daniel, Richmond	B. T. Beasley, Atlanta	Richmond, Mar. 12-15, '56
ast Clinical Society	Walter C. Payne Sr., Pensacola	Barkley Beidleman, Pensacola	Pensacola, Oct. 27-28, '55

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County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Total Members
Alachua	Edwin H. Andrews, Gainesville	Henry S. Blank, Gainesville	2nd Tues.	57
***Bradford, Gilchrist, Union**				
Bay	William F. Humphreys Jr., Panama City	Roderick C. Webb, Panama City	1st Tues.	28
Brevard	Lee Rogers Jr., Cocoa	Charles E. Russell, Cocoa	2nd Tues.	37
Broward	Ernest E. Serrano, Hollywood	Alfred E. Cronkite, Fort Lauderdale	4th Tues.	121
Columbia	Robert B. Harkness, Lake City	Thomas H. Bates, Lake City	1st Mon.	11
***Baker**				
Dade	L. Washington Dowlen, Miami	Robert F. Dickey, Miami	1st Tues	724
DeSoto-Hardee-Highlands-Glades	Gordon H. McSwain, Arcadia	Harold S. Agnew, Arcadia	1st Tues.	28
Duval	Raymond H. King, Jacksonville	Eugene M. Frame, Jacksonville	1st Tues.	300
***Clay**				
Escambia	George W. Morse, Pensacola	Paul F. Baranco, Pensacola	2nd Tues.	107
***Santa Rosa**				
Franklin-Gulf	Warren T. Weathington, Apalachicola	Joseph P. Hendrix, Port St. Joe	Last Wed.	6
Hillsborough	Frank S. Adamo, Tampa	Julien C. Pate Jr., Tampa	1st Tues.	189
Indian River	Kip G. Kelso, Vero Beach	Vernon L. Fromang, Vero Beach	2nd Tues.	9
Jackson-Calhoun	Henry I. Langston, Marianna	Francis M. Watson, Marianna	Quarterly	17
Lake	Louis R. Bowen, Eustis	J. Basil Hall, Tavares	1st Wed.	29
***Sumter**				
Lee-Charlotte-Collier-Hendry	Baker Whisnant, Fort Myers	James L. Bradley, Fort Myers	3rd Mon.	38
Leon-Gadsden-Liberty-Wakulla-Jefferson	William L. Hunter, Monticello	Odis G. Kendrick Jr., Tallahassee	Quarterly	66
Madison	A. Franklin Harrison, Madison	Wallace E. Winter, Madison		6
Manatee	Marjorie L. Warner, Bradenton	Harvey C. Pauley Jr., Bradenton	2nd Tues.	31
Marion	William H. Turnley, Ocala	Bertrand F. Drake, Dunnellon	3rd Tues.	30
***Levy**				
Monroe	Ralph Herz, Key West	William R. Ploss, Key West	1st Thurs.	14
Nassau	David G. Humphreys, Fernandina Beach	John W. McClane, Fernandina Beach	Last Fri.	11
Orange	Don C. Robertson, Orlando	Walter A. Derrick, Orlando	3rd Wed.	193
***Osceola**				
Palm Beach	Edwin W. Brown, West Palm Beach	James R. Anderson, West Palm Beach	4th Mon.	143
Pasco-Hernando-Citrus	Harry G. Brownlee, Zephyrhills	W. Wardlaw Jones, Dade City	2nd Thurs	16
Pinellas	Clyde O. Anderson, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	227
Polk	Samuel J. Clark, Lakeland	Marion W. Hester, Lakeland	2nd Wed.	101
Putnam	Grover C. Collins, Palatka	Alfred P. Peretti, Palatka	2nd Tues.	10
St. Johns	George C. Hopkins, St. Augustine	Reuben J. Plant Jr., St. Augustine	3rd Tues.	21
St. Lucie-Okeechobee-Martin	Henry E. Branca, Fort Pierce	Adrian M. Sample, Fort Pierce	3rd Thurs	24
Sarasota	Melvin M. Simmons, Sarasota	Andrew J. Jesacher, Sarasota	2nd Tues.	58
Seminole	John M. Morgan, Sanford	Terry Bird, Sanford	2nd Tues.	20
Suwannee	William P. Blackmon, Jasper	Hiram B. Curry, Jasper	1st Sat.	10
***Hamilton, Lafayette**				
Taylor	John H. Parker Jr., Perry	Ralph J. Greene, Perry	Last Fri.	5
***Dixie**				
Volusia	Robert L. Miller, Daytona Beach	Achille A. Monaco, Daytona Beach	2nd Tues.	84
***Flagler**				
Walton-Okaloosa	Richard H. Lee, Crestview	Frederic E. Caldwell, Fort Walton Beach	3rd Tues	20
Washington-Holmes	L. H. Paul, Bonifay	Bayllye W. Dalton, Chipley		5

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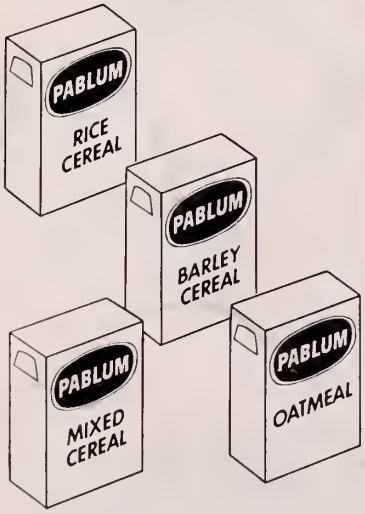


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The Journal OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XLII SEPTEMBER, 1955 No. 3

MEDICAL DISTRICT MEETINGS
OCTOBER 10-14, 1955

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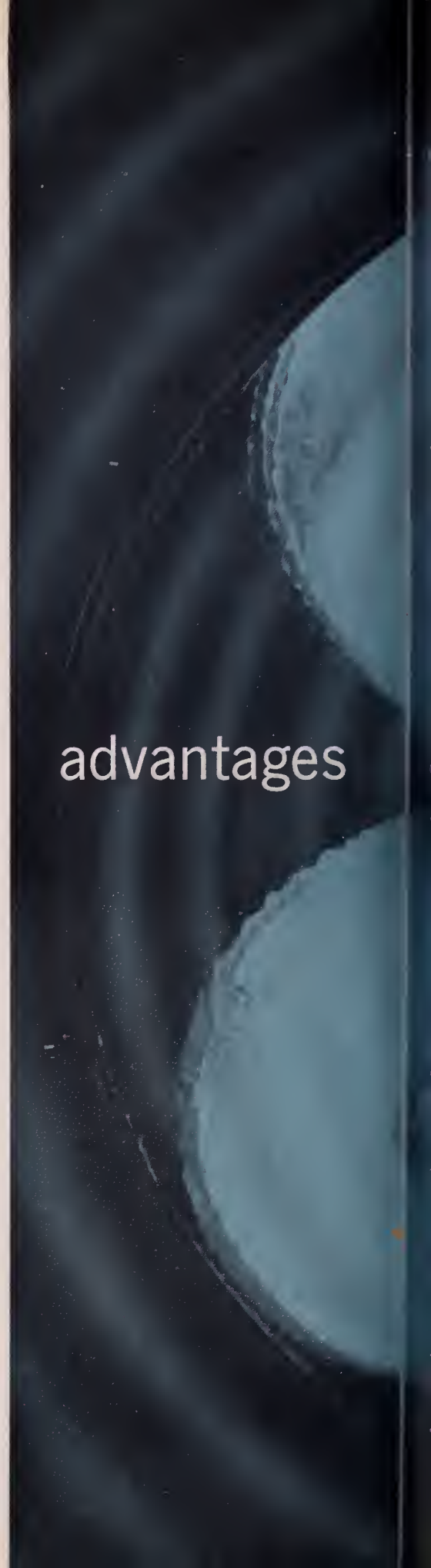
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Peter B. Wright

Protein-Bound Iodine – A Newer Aid in Medical Diagnosis
Nelson A. Murray

Clinical Management of Peripheral Vascular Disease
Charles K. Donegan

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Keynote of Twentieth Century Medical Progress
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Volume XLII SEPTEMBER, 1955 No.

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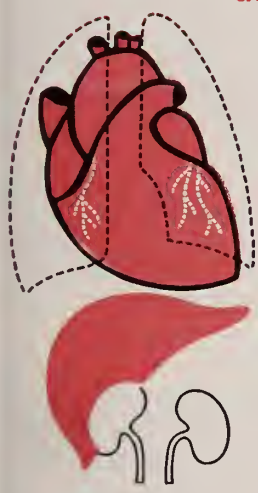
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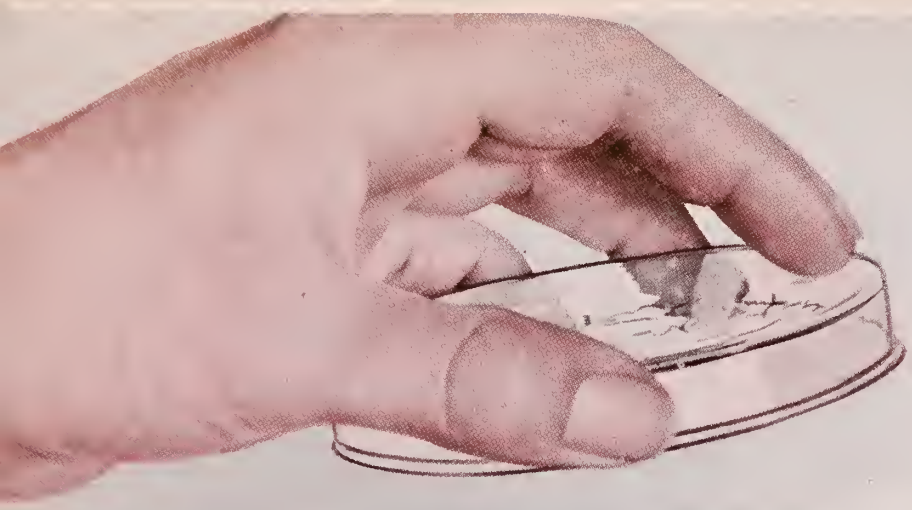
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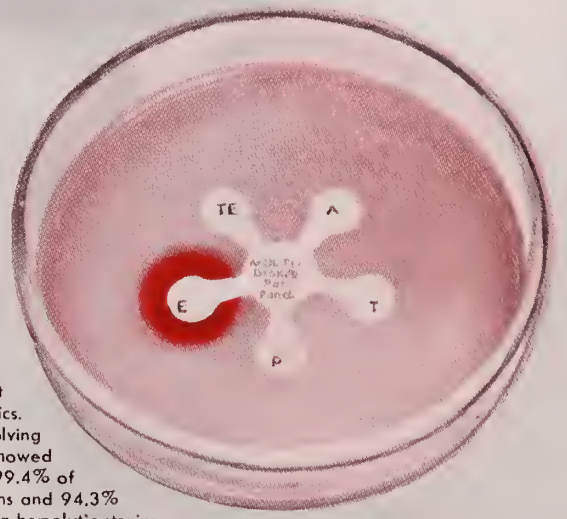
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1. Eisenberg, et al., Antib. & Chemo., 3:1026-1028, Oct., 1953.

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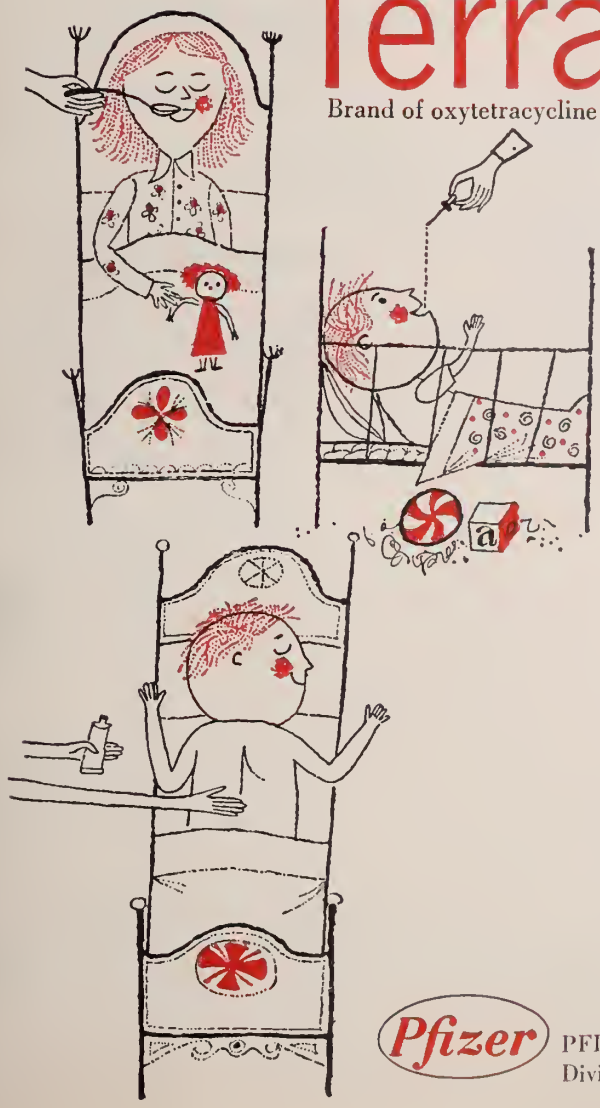
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*Farley, W. J.: Oxytetracycline in Pediatrics. Internat. Rec. Med. *168*:140 (March) 1955.

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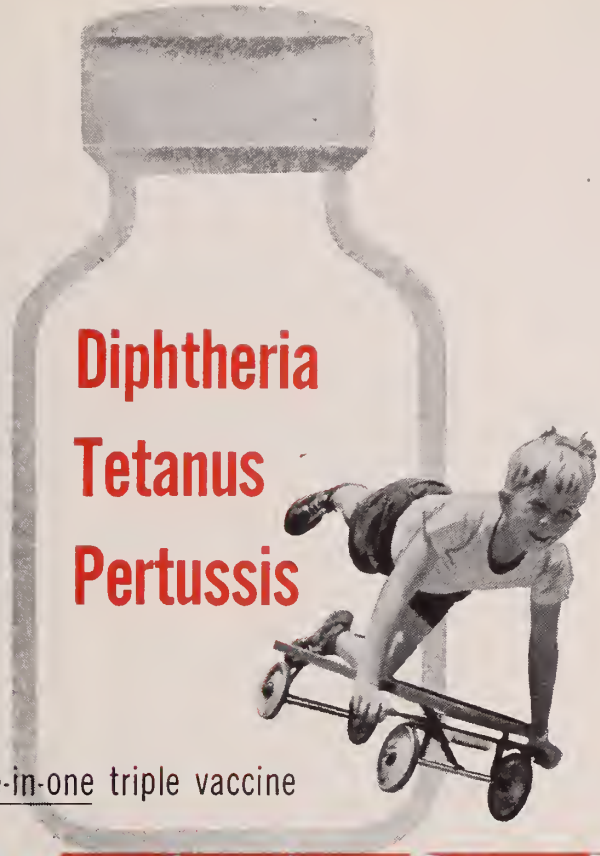
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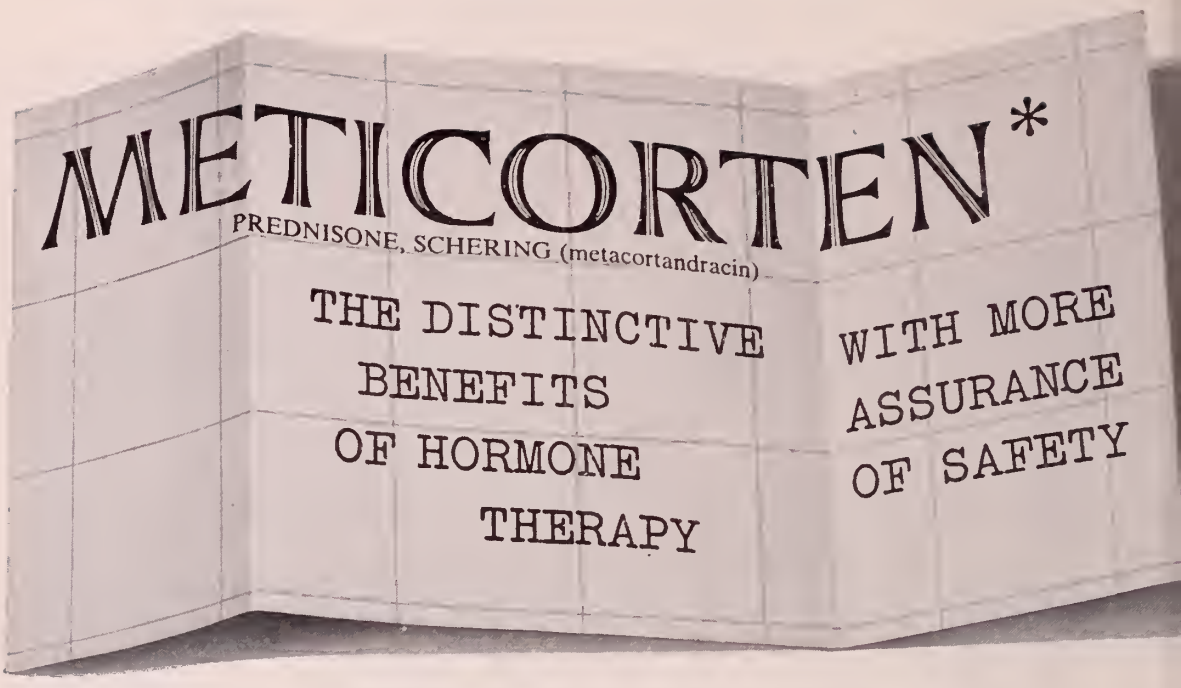
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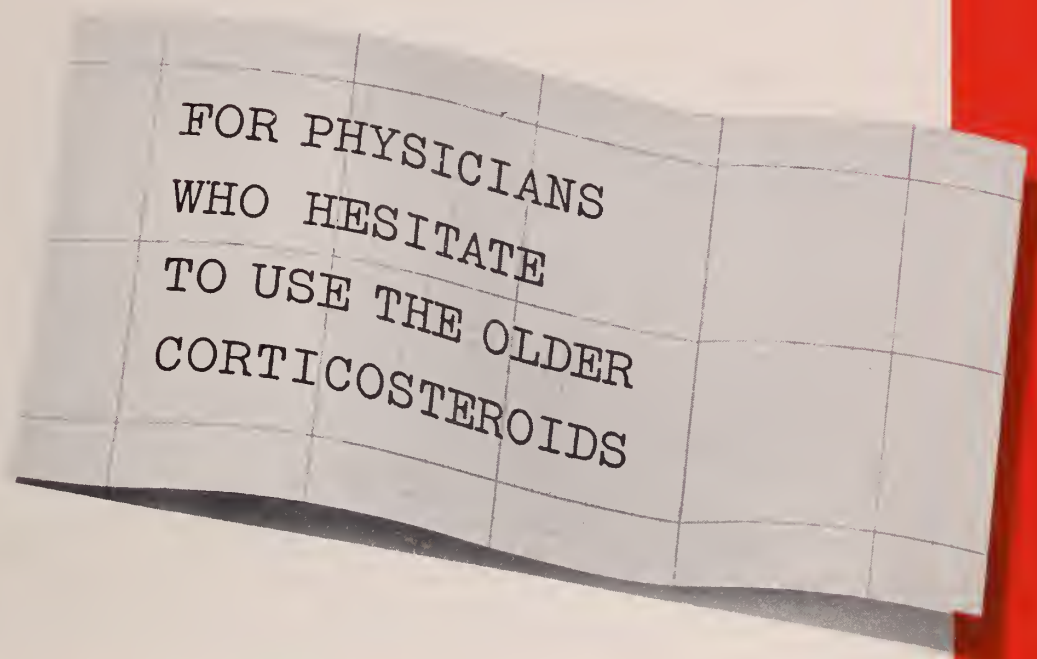
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
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The Emergency Treatment of The Injured

Peter B. Wright, M.D.
AUGUSTA, GA.

During the year of 1953 approximately 9,600,000 accidents were reported in the United States. Of this number there were 95,000 fatal accidents recorded. Deaths from accidental causes stood in seventh place amongst the killers in 1925, and today this cause of death stands in fourth place. In the age group of 1 year to 36 years accidents account for more deaths than any other cause. The monetary total amounted to $9,700,000,000.

Industry has long been aware of the financial loss and the work day loss due to accidents and has made great strides forward in the prevention as well as the adequate first aid care of injuries. Positions such as efficiency and safety engineers have been established in order to safeguard the workers. Medical personnel and equipment for the immediate care of the injured also are provided. First aid teams have been formed and properly trained for the task.

The automobile manufacturers not only have eliminated hazards on cars but are devoting much time and expending large sums of money in their efforts to provide safety devices such as the padded dash, blunt instead of sharp instruments on the panel and steering wheel, push-out windshields and seats designed to protect the passengers within the car. Safety belts have proved their worth and should soon be standard equipment.

The highway patrols in many states are striving to eliminate reckless and careless drivers and establish safety rules and regulations that will be enforced. They, too, have training in first aid and in handling the injured properly. Local police and fire departments have first aid teams in many cities.

Prevention of death or permanent disability from an injury begins at the scene of the accident; consequently first aid and emergency handling of the injured will, in 95 per cent of the cases, be rendered by lay people. We of the medical profession, therefore, should be completely versed in the approved methods of the immediate care of the injured in order that we may impart our knowledge to this group. We must face the situation with as much seriousness and determination as industry, police, firemen, Boy Scouts and the laity.

After receiving adequate emergency attention the patient must be transported to the hospital or home. Properly equipped ambulances and trained ambulance attendants are another must. The attendants should be required to take the Red Cross course and have certification for it. Rarely is it necessary for an ambulance to speed; fatal accidents have, too often, resulted from this error. Many deaths have resulted from a fast ride in an automobile furnished by an overanxious motorist, who is inexperienced in handling the injured. Haste is rarely necessary and can do more harm than the lapse of the short time it takes to get an ambulance and provide adequate and safe transportation.

Medical schools make little or no effort toward the teaching of first aid and emergency care of the injured. Sad, but true, the average medical student upon receiving his M.D. degree knows little about it. Unfortunately, the new intern, who is placed on emergency room service, has had but meager experience and frequently has to rely on the advice of the nurse in charge or may-

From the Department of Orthopedic Surgery, Medical College of Georgia, Augusta, Ga.
Read before the Florida Medical Association, Eighty-First Annual Meeting, St. Petersburg, April 4, 1955.

be an orderly. There is little doubt but that the emergency room service to the injured is far from being adequate in most hospitals in this country. Death from injuries is by no means always due entirely to the accident, but also may occur from the improper and inadequate emergency treatment and handling. The weakest spot in the whole system for the care of the injured is in that uncertain period of time between arrival at the hospital and the definitive treatment. The patient may arrive at the hospital, having received excellent first aid care and having been properly bandaged and splinted, and then may be subjected to the worst of care. Usually he is removed from the ambulance stretcher to the hospital stretcher, then to the emergency room table, then to the hospital stretcher, then to the x-ray table, then back to the hospital stretcher and finally to the operating table or the bed.

The Committee on Trauma of the American College of Surgeons has, for a long period of years, considered it the duty of the committee to improve: the immediate handling of the injured, the transportation of the injured, the emergency room care of the injured and the definitive treatment of the injured. This committee is composed of general surgeons, neurosurgeons, urosurgeons, thoracic surgeons, orthopedic surgeons, plastic surgeons, and hand surgeons, all of whom realize the necessity of the anesthesiologists and the internists. We also realize that the general practitioner will be called to treat the patient in the great majority of these cases; so in order to be of more service to the cause, the committee has edited two books: An Outline of the Treatment of Fractures, and Early Care of Acute Soft Tissue Injuries. These are available to everyone and will fit in the intern's or resident's coat pocket.

Since it is impossible to cover the entire subject of trauma and the emergency care of the injured, some of the more frequently encountered injuries will be considered.

At the scene of the accident in industrial plants there is usually a first aid team and readily available medical care. On highways, however, there usually is no one present who is trained in first aid. To reiterate, the injured should be transported safely after receiving adequate emergency treatment. Removal of the injured from wrecks must be done expertly and not with too much haste. I know of 2 cases in which the spinal cord was transected by forcefully pulling a patient from a wrecked automobile when the primary injury was a fractured spine with no paralysis.

Hemorrhage

It is not necessary to identify pressure points; pressure dressings will usually control the bleeding. Tourniquets are dangerous and should rarely be used. More deaths have resulted from unnecessary and improper application of them than from failure to apply them. Hemorrhage, however, must be stopped, and if the tourniquet is the last resort, it should be used.

Shock

Immediate drop in blood pressure (less than 100), increased pulse rate (100 or more), cold extremities, pallor, cold clammy skin and collapse usually mean that 30 per cent or more of the normal circulating blood volume has been lost. The blood volume must be maintained with the use of plasma expanders until whole blood is available. If these symptoms occur six to eight hours after injury, they still mean loss of blood and are not due to a nervous reaction or infection. It has been demonstrated that with each closed fracture of a femur, the average loss of blood from the vascular tree is from 800 to 1,200 cc.

Pain

Pain must be relieved, but if shock is profound, intravenous administrations must be used, as the sluggish capillary circulation cannot deliver the drug.

Conditions which may produce the signs and symptoms of shock when there has been no loss of blood are: cranial trauma (cerebral), cardiac tamponade, and respiratory embarrassment arising from multiple rib fractures, pneumothorax, sucking wounds of the chest, obstructed airway and other causes, all of which must be watched for and treated according to the requirements.

Head Injuries

Open wounds should be covered with sterile gauze and a pressure dressing to control the bleeding. No narcotic drug should be given. A patent airway must be assured and oxygen supplied if there is evidence of suboxygenation. The patient should be placed in a prone position with the foot of the stretcher elevated so as to establish postural drainage.

Chest Injuries

Injuries of the chest are divided into three groups: (1) Nonpenetrating wounds resulting from a blow, while producing no laceration of the

skin, may cause serious injury to the lungs, heart and great vessels, or even to the esophagus. Respiration should not be depressed by overdosage with narcotic drugs, but enough may be given to relieve severe pain. The air passages should be patent and oxygen administered if necessary. (2) Penetrating wounds or the sucking wounds should be covered with vaseline gauze and the therapy mentioned should then be administered. (3) Perforating wounds should receive the same care, but it should be remembered that two wounds may be requiring attention. The loss of the ability to cough may result in obstruction of the bronchial tree. This is best combated by Novocain blocking of the intercostal nerves, which relieves the pain of coughing. The administration of narcotics should be undertaken with extreme caution.

Abdominal Injuries

Injuries to the abdomen may be penetrating, and the diagnosis is not often difficult as the missile or instrument will usually reveal the course of the injury and the probable organs which have been damaged. A pressure binder may be applied over sterile dressings in order to control hemorrhage. The nonpenetrating wounds are dangerous and hard to diagnose. No narcotics should be given as they may mask the symptoms, such as localized pain, general pain, rigidity due to peritoneal irritation and ileus. In such cases especially close observation and an ever ready operating room are required.

Genitourinary Injuries

If there is a fracture of the pelvis, an associated injury of the bladder or urethra may be present. The urinary injury takes precedence over the fracture and requires immediate attention. It is an established fact that the full bladder is more vulnerable to trauma than the empty one; therefore, the Committee on Trauma advised motorists not to stretch the distance between stops at rest stations too far. A voided specimen will tell the story as to whether or not there is injury to the urinary system and if this is not obtainable, catheterization is indicated. Questionable trauma to the kidney usually can be proved by intravenous pyelograms. Again, the genitourinary injuries demand prior attention over a fractured pelvis.

Spine Injuries

The proper handling of patients with injury to the spine is of paramount importance. An accurate history of the mechanism of the injury is most important in the handling of cases of this type. A flexion or jack-knifing injury will result in a compression fracture of the vertebral bodies, and the anterior longitudinal ligament will be intact. The tensile strength of this ligament is approximately 350 pounds, and the patient may be safely lifted in the prone position, which hyperextends the spine without fear of causing further damage. Through the stretching force of hyperextension the annulus fibrosus pulls the crushed vertebral body back to its normal height and thus reduces the fracture. Lifting the patient in the supine position flexes the spine and may result in transection or serious damage to the spinal cord. Lifting the patient in the prone position is not only safe but beneficial. The positioning of the patient is also of extreme importance. On the ambulance stretcher with the patient in the prone position the head may be elevated to produce hyperextension, and on the bed a pillow should be placed under the back, in the supine position, in order to maintain hyperextension. Sagging into a flexed position is not permissible. Immediate reduction of the fracture and the application of a hyperextension cast or brace is the choice method of treatment.

Should the fracture be produced by hyperextension, the anterior longitudinal ligament may be ruptured; then lifting in the prone position may produce further damage. A history of the mechanism of the injury is therefore most essential. In the event of a hyperextension injury the safe way to handle the patient is with neither flexions nor hyperextension. The ladder splint is a safe transportation splint. It can be placed on the ground and the patient gently rolled over on it. Traction on head or lower extremities can be accomplished on this splint.

Immediate and complete paralysis following fracture of the spine means transection of the cord, and surgery is not indicated. Paralysis developing slowly over one to several hours will be due to hemorrhage and increased intraspinal pressure; in this case surgery is imperative. Paralysis developing one to 10 days after the injury is due to edema, and surgery is contraindicated.

Upper Extremity Injuries

Associated with a fractured humerus there may be blood vessel or nerve damage. A rapidly developing hematoma is indicative of arterial bleeding and will require immediate attention,

while a slowly developing hematoma is of venous origin and is not usually serious. The circulation below the site of the injury should be examined in every case; this examination includes observation of the capillary circulation as well as major vessels. Determination of nerve injury is necessary because if the limb is splinted without this information, it may be impossible to say whether the injury or handling or the splint caused the nerve damage.

The sensory distribution of the three main nerves of the upper extremity as well as their motor supply should be tested for possible injury. Should the ulnar nerve be severed, the most outstanding symptom will be complete anesthesia of the fifth finger. In case of median nerve injury there will be anesthesia of the tips of the second and third fingers. Injury to the radial nerve produces anesthesia of the thenar region, and most often there will be a wrist drop. Angulation, if not corrected, will cause pressure on a blood vessel or nerve.

Muscle influence should be understood, and splinting in the position demanded by this mechanism is a must. In the case of fracture of the humerus above the insertion of the pectoralis major, the teres major and latissimus dorsi, the upper fragment will be pulled into an abducted position by the supraspinatus, infraspinatus and teres minor. The long, lower and controllable fragment must be abducted to align it with the uncontrollable upper fragment. Fractures below this level will result in adduction of the upper fragment because of the influence of the more powerful three muscles.

Fractures of the humerus should be splinted for transportation. The Thomas arm splint is ideal for this purpose and allows for traction, which is often indicated. Subfascial hemorrhage may produce enough pressure to cause ischemia of the muscles resulting in ischemic (Volkmann's) contracture. Subfascial tension must be relieved. There are two types of supracondylar fracture of the humerus. The flexion type is usually suffered by adults and offers little threat to the brachial artery. The hyperextension type is frequent in children and produces a real threat to the brachial artery. If the elbow is flexed before the fracture is reduced, irreparable damage can result. In this type of fracture it is imperative that the circulation in the wrist and finger tips be studied. It goes without saying that this is by far more important than the fracture. Immediate surgical intervention is mandatory if closed manipulation does not restore the circulation.

Lower Extremity Injuries

In femoral neck and trochanteric fractures the limb is externally rotated, and for transportation the limbs may be bound together with the toes pointing up while the patient is in the supine position. Fractures of the shaft must be splinted for transportation. The Thomas leg splint is excellent and provides for traction and countertraction. Fractures of the supracondylar region require additional attention. The gastrocnemius pulls the upper end of the distal fragment into the popliteal space, and if the limb is splinted with the knee in full extension, the popliteal artery will be compressed, perforated or torn. A pillow keeping the knee in moderate flexion will eliminate the hazard. Fracture dislocation of the ankle (Pott's fracture) will frequently obstruct the circulation, and it is wise to reduce the deformity before splinting, even without an anesthetic.

Burns

The vast majority of burns can be prevented. Open fireplaces should be screened. Gas stoves I consider dangerous both from the standpoint of burns and asphyxiation and do not recommend their use. The disasters incident to pouring kerosene and gasoline on fires in an effort to boost them are well known to all; emphasizing them is not necessary. In rural areas where open fires are most used, it will be noted that girls receive the greater number of burns. It would therefore be wise for them to wear blue jeans rather than dresses and pajamas rather than nightgowns. Fabrics vary in their inflammatory properties, and clothing, especially for children, should be made of the slow-burning rather than the flash-burning ones.

The emergency attention of burns consists simply of covering the burned areas with voluminous sterile dressings to exclude the air and for protection. No grease, no ointment and no local medication should be used.

General Factors

Trauma calls forth a metabolic body response resulting in a great increase of nitrogen excretion as well as an increase in the excretion of potassium and the 17-ketosteroids. The loss of 20 or more grams of nitrogen per day is to be expected in the case of a fracture of a large bone, and since the loss exceeds the normal intake we might well expect rapid loss of body weight. An early in-

crease in the intake of nitrogen for the injured may not offset the loss during the first week, but definitely seems to shorten the period of recovery.

While immobilization sometimes must be extensive, we must be aware of the fact that it will increase the excretion of calcium, phosphorus, sodium, nitrogen and postassium. We must, therefore, from the beginning of treatment of the injury set about to offset these losses by increasing the intake of these essential elements. It becomes evident that early mobilization, ambulation and activity will tend to decrease their loss, and during the immobilizing period physical therapy and muscle exercises are most important.

The mental reaction of a patient is also most important, and first impressions made upon him in the primary stages of treatment are lasting. We can gain his confidence and lasting gratitude by being prompt, efficient and kind while administering first aid at the scene of the accident, in the course of transportation, in the emergency room and during definitive treatment. A mentally depressed trauma patient is most difficult to rehabilitate.

There is a keen professional and moral obligation to provide the best immediate care, transportation, emergency room handling and definitive care for the injured.

Protein-Bound Iodine – A Newer Aid in Medical Diagnosis Report of 700 Cases

Nelson A. Murray, M. D.
Jacksonville

Over 2,000 years ago it was realized that there was a connection between goiter, exophthalmos, and some unknown nutritional factor. The ancient Greek physicians treated these conditions with burnt sea sponges and obtained remarkable results. The true nature of the correlation was not placed on a scientific basis, however, until the isolation of thyroxin by Kendall in 1919. At that time, Kendall also showed that the iodine concentration of ox blood was approximately 13 gamma per hundred cubic centimeters. In 1941 the separation of the blood iodine into fractions was accomplished, and since that time the technic has been constantly improved. At the present time, the technic available, under proper conditions, will measure a difference of about 1 gamma per hundred cubic centimeters of serum or 1 part in 100 million. Properly performed, the protein-bound iodine test is one of the most sensitive and accurate chemical tests known today. It is probably the most definitive test in the entire field of clinical chemistry. It is, however, a sub-micro procedure, and its actual performance is extremely exacting. In this report the factors relating to the clinical employment of this test will be summarized, as will be personal experiences encountered during the performance of some 700 protein-bound iodine examinations.

Read before the Florida Medical Association, Eighty-First Annual Meeting, St. Petersburg, April 4, 1955.

Protein-Bound Iodine and Thyroxin

Practically all of the organic iodine in serum is bound to protein. This protein-bound iodine makes up about 90 per cent of the total serum iodine; the remaining 10 per cent is, for practical purposes, composed of inorganic iodine. This has been well illustrated graphically by Sunderman and Sunderman.[1] It has been shown by Taurog and Chaikoff[2,3] that the level of serum protein-bound iodine quantitatively reflects the level of circulating thyroxin. Similar studies have been made by Chesky and his associates.[4] Thus, when the protein-bound iodine value of the serum is determined, a practical blood thyroxin level is obtained. The level of circulating thyroxin would seem to be the most accurate measurement of thyroid function currently available.

Normal Values for Protein-Bound Iodine

During the last three years, approximately 400 samples from normal bloods and 300 samples from abnormal bloods have been examined in our laboratory, my associates and I employing a modification of the alkaline ash method of Barker, Humphrey and Soley.[5] During the first year results were consistently about 1 gamma lower than those reported by other workers. More recently our normal values have been consistent with the national average (3 to 8 gamma per hundred cubic centimeters). The earlier lower values, in my opinion, were due to the employment of H_2SO_4 as described by the original authors. Brown, Reingold and Samson[6] also reported low values when H_2SO_4 is used. At present, our laboratory uses 3 cc. of 2N HCl to take up the ash; no H_2SO_4 is used. Figure 1 represents 419 consecutive cases in which the test was performed with this modification. The method has been further simplified by the elimination of some of the time constants during the reading period and by use of an automatic calculator for deriving the final answer, to be reported elsewhere. A standard is run each time, and no graphs are used.

Physiologic Variations in Protein-Bound Iodine Values

It is well recognized that the protein-bound iodine value increases in pregnancy. Danowski and his associates[7] reported the mean value of 7.8 gamma per hundred cubic centimeters in 57 pregnant women. Man and her associates[8] reported values to 6 gamma per hundred cubic centimeters during the first 16 weeks of pregnancy. These latter workers also noted that if the protein-bound iodine value does not rise to 6 gamma or above during this period, the pregnancy is unlikely to proceed to term. Increased protein-bound iodine values during pregnancy have been observed in our laboratory.

Increased values in newborn infants have been reported by Danowski and his associates.[9] Significant changes in these values in advanced age, during periods of stress, and during menstruation have not been reliably documented at the present time.

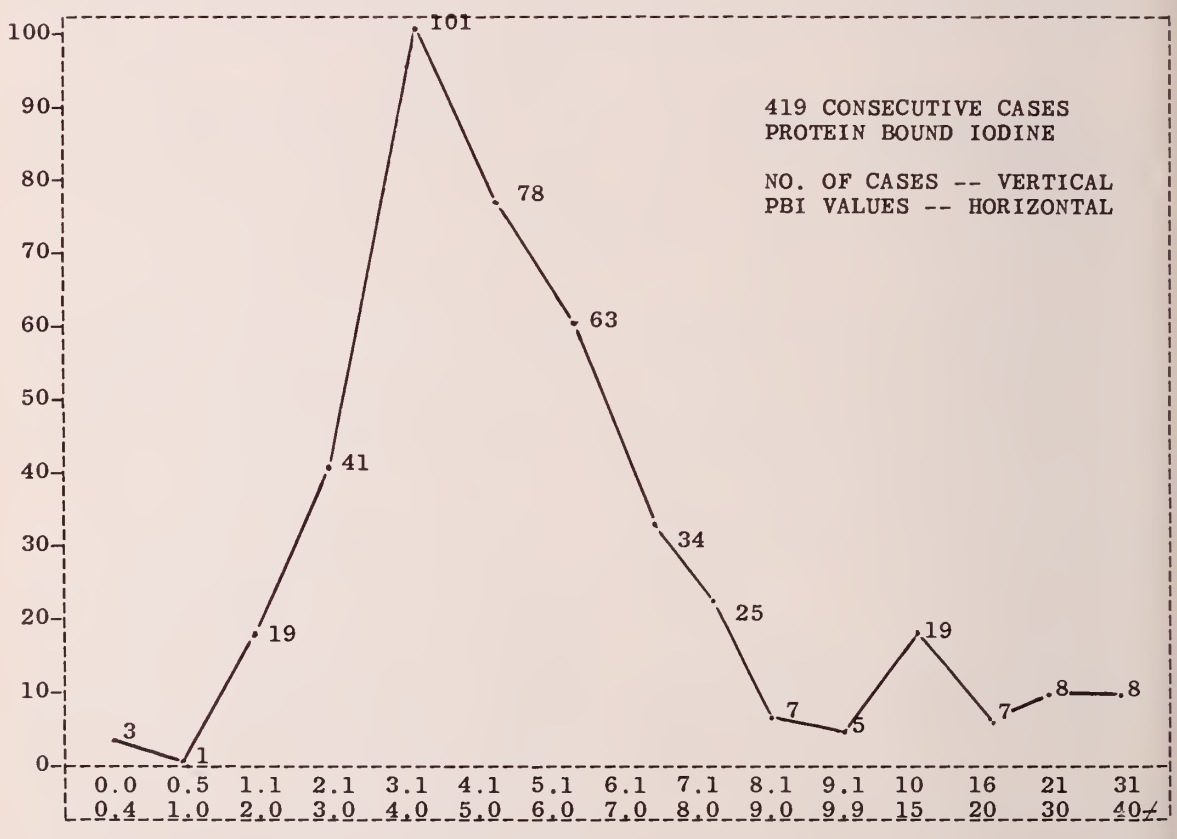


Figure 1

Pathologic Variation in Protein-Bound Iodine

The protein-bound iodine level of the serum is increased at any time there is an increased level of circulating thyroxin. So far as is known at present, a pathologic increase in protein-bound iodine is present only in hyperthyroidism, early hepatitis, immediately following thyroidectomy, and in patients under certain types of drug therapy.

Likewise, the protein-bound iodine level of the serum is decreased at any time the circulating thyroxin is decreased. As is now known, a pathologic decrease is only noted during hypothyroidism, hypoproteinemia (nephrosis) and during the administration of certain drugs.

In our laboratory we have noted values less than 1.0 gamma in hypothyroidism, nephrosis, Riedel's struma, postoperative thyroidectomy, encephalitis, and in 1 case in which we have no explanation. In the case of a cardiac-diabetic patient taking a myriad of drugs there were repeated readings of zero. In 1 case in which the patient had been under cortisone medication for over two years, the protein-bound iodine value was 3.0 gamma.

We have noted the usual high values in hyperthyroidism, hepatitis, and following the use of iodine-containing drugs. Recently we have noted high values following therapy with Chiniofon and Diodoquin.

Drugs Affecting the Serum Protein-Bound Iodine Level

Any drug containing iodine in its chemical makeup will, of course, increase the apparent level of serum protein-bound iodine. The drugs containing organic iodine probably form iodine complexes with the serum proteins and are thus precipitated. These drugs will cause increased (artifactual) protein-bound iodine values for many months. Whether or not inorganic iodine (Lugol's solution and potassium iodide) forms a protein complex or is physically bound to the protein is questionable. At any rate, high values are obtained, and the usual washing procedure will not remove this inorganic iodine. Possibly 20 or 30 washings may eliminate this iodine, but this is impractical. The serum protein-bound iodine levels return to normal in two to five days after the cessation of inorganic iodine therapy. This rapid return to normal has been repeatedly observed in our laboratory.

The following drugs have been noted to increase artifactually the value of serum protein-bound iodine: Cholegraphin, Pantopaque, Salpix, Neo-Iopax, Iodochlorol, Telepaque, Priodax, Lipiodol, Tetraiodophenolphthalein, penethamate (Neo-Penil), Diodoquin, Chiniofon, diethylstilbestrol, potassium iodide, Lugol's solution, iothiouracil (Itrumil), and vitamin preparations containing iodine. Likewise a decrease has been noted following the administration of ACTH and cortisone. Mercury and barium compounds are precipitated with the protein-bound iodine and will cause low results with the distillation procedure. The alkaline ash method, however, is apparently not affected by these drugs. An increase in protein-bound iodine is noted immediately following the administration of radioactive iodine (I^{131}). A decrease in protein-bound iodine may be noted at long intervals following the administration of radioactive iodine, due to the depressing action on thyroid function. (The half life of I^{131} is eight days.)

Of course, thyrotropic drugs will have a true (nonartifactual) effect on the serum protein-bound iodine. Thyroid substance and thyroxin will elevate the protein-bound iodine, both by physiologic function and by their iodine content, in a patient suffering from hypothyroidism, according to Man, Culotta, Siegfried and Stilson[10] and Winkler, Riggs and Man.[11] These latter authors stated in the same paper that a 1 grain increase in the daily dose of desiccated thyroid administered to patients with hypothyroidism occasions an increase in the total serum iodine of 2.0 gamma per hundred cubic centimeters. No further reference can be located in which there is a scientific correlation between the dosage of a thyrotropic drug and the serum protein-bound iodine. An increase in protein-bound iodine levels following the administration of desiccated thyroid has been noted in our laboratory.

Thiouracil will lower the serum protein-bound iodine in patients suffering from hyperthyroidism according to Engstrom, Kydd, Man and Peters.[12] This change has been observed repeatedly in our laboratory. These authors also stated that a very low protein-bound iodine level during thiouracil therapy indicates overdosage. Strangely enough, in normal, healthy adults given up to 6 grains of desiccated thyroid daily for as long as 10 weeks no significant changes in the serum protein-bound iodine were observed by Danowski and his associates.[13]

Discussion

Once the technical difficulties inherent in a submicro procedure are mastered, the serum protein-bound iodine determination is extremely valuable to the clinician and surgeon as an aid to the evaluation of patients with hyperthyroidism and hypothyroidism. Additional experience may enable us to correlate the serum protein-bound iodine levels with the duration and intensity of thyroid disease.

Unlike the basal metabolic rate, the protein-bound iodine level is not dependent on the emotional and outward physical condition of the patient, according to Robertson and Kirkpatrick,[14] and Meckstroth, Rapport, Curtis, and Simcox.[15] The protein-bound iodine determination will readily uncover masked hyperthyroidism associated with cardiovascular disease according to Allison and Bliss[16] and Silver, Crohn and Porto.[17] It is extremely valuable in children, whereas the determination of a basal metabolic rate may, at times, be impossible. Likewise, the protein-bound iodine determination is useful in the elimination of thyroid disease when one attempts to evaluate psychic disturbances. We have employed a simple protein-bound iodine tolerance test, similar to the glucose tolerance test. A fasting protein-bound iodine specimen is drawn; then the patient is given 10 drops of Lugol's solution. In an euthyroid patient there will be a 400 to 600 per cent increase in the protein-bound iodine level, while in a patient with hyperthyroidism the increase will be less than 100 per cent in 48 to 72 hours. This test will be applied to patients with hypothyroidism in the near future.

Comparisons of the various tests for thyroid function have previously been made by Meckstroth, Rapport, Curtis, and Simcox.[15] On correlation of the various tests with clinical findings, the protein-bound iodine shows 95 per cent agreement, radioactive iodine 89 per cent, cholesterol 72 per cent, somnolent metabolic rate 53 per cent, and basal metabolic rate 0 per cent. The somnolent metabolic rate is, of course, superior to the basal metabolic rate in the evaluation of thyroid status, but in my opinion it is not as valuable as the protein-bound iodine level. The serum cholesterol level is also useful, particularly in hypothyroid states, but its correlation with the clinical picture has not been impressive.

Radioactive iodine (I^{131}) has been used in several tracer technics to evaluate thyroid activity. The most widely used technics include (1) thyroid uptake,[18] (2) urine excretion,[18] (3) conversion ratio,[19] and (4) profile counting.[18]

In the more refined forms of I^{131} tracer studies, the scintillation counter is used in conjunction with some form of scaler. These instruments are both expensive and temperamental. Possibly some of the newer uranium survey instruments which employ thorium-activated iodide crystals and total the gamma radiation without scaling will offer a less expensive and easier method of measurement in tracer studies. Such an instrument is now under development in our laboratory.

Summary

The determination of serum protein-bound iodine offers the most valuable information of any single test in the evaluation of thyroid status. It is not necessary for the patient to be present while the test is being performed.

The protein-bound iodine values for normal persons fall in the range of 3 to 8 gamma per hundred cubic centimeters.

The elimination of H_2SO_4 in the final steps will increase the accuracy of the determination.

The reading of the values from a precalibrated graph is not recommended.

The procedure is simplified by the elimination of some of the time constants and the employment of an automatic calculator to derive the final answer.

The protein-bound iodine tolerance test offers confirmatory data in evaluating thyroid status.

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Discussion

Dr Samuel W. Root, Jacksonville: Dr. Murray is to be congratulated upon the performance of a large series of these determinations, which is an exceedingly exacting procedure, and his results have been very reproducible and most excellent. The determination of the protein-bound iodine is certainly the most direct test of thyroid function since it measures the thyroid hormone actually circulating in the blood. It does not, however, tell anything about the reactivity of the tissues to the thyroid hormone, and this may be variable under certain situations not too well understood. Use of the radioactive iodine uptake study measures the thyroid from a different aspect. It measures simply the avidity of the thyroid for iodine and is hence an indirect measurement. In certain circumstances, however, it gives information which is not given by the protein-bound iodine determination. One of these is scanning patients who have a mediastinal mass, after having given them a dose of radioactive iodine, with a collimated geiger tube or scintillation counter to determine whether or not the mass is of thyroid origin, thus helping to show whether or not a substernal thyroid is present. Also scanning patients with thyroid carcinoma for evidence of metastatic lesions. The protein-bound iodine may be low in cases of severe nephrosis, possibly because there is a large amount of albumin lost in the urine with a loss also of thyroid hormone bound to it. In this situation the iodine uptake will be about normal. Another instance in which the radioactive iodine uptake study will throw some light on the situation is in the case of acute thyroiditis, a nonspecific inflammatory type of reaction in which the patient may appear mildly toxic. In such a situation protein-bound iodine may be slightly elevated; the radioactive iodine uptake study will be practically zero, maybe 2 or 3 per cent.

Another test of thyroid function which is not used widely is the so-called radioactive iodine conversion ratio. This is performed by giving the patient a dose of radioactive iodine and determining the total activity in the plasma, and then precipitating the protein and determining the radioactivity in the precipitated protein. The amount which is bound to the protein is relative to the amount of thyroxin and by forming a ratio one can get an index of the conversion to thyroxine of the radioactive iodine administered.

One point about the interference of the protein-bound iodine determination by the previous administration of radioactive iodine. I do not think that it is quite correct to say that a tracer amount of radioactive iodine will increase the protein-bound iodine because the amount of radioactive iodine atoms which are administered is so minute in terms of atoms of iodine that I do not believe that they will interfere even with this very sensitive determination. Since they are present in a tracer dose in the range of one hundred-thousandth of a microgram, they should not introduce a source of error.

Dr. Murray, concluding: The main point is that following therapeutic doses of radioactive iodine the protein-bound iodine level of the blood will decrease because of the depressing action of the radioactive iodine on thyroid function. The protein-bound iodine level would decrease following any intensive antithyroid therapy. The protein-bound iodine of course will increase following intensive thyroid therapy. One point that one group of investigators has made is that the determination of protein-bound iodine during the course of treatment with antithyroid drugs is extremely valuable. When a patient under antithyroid therapy shows an extremely low protein-bound iodine, it is the opinion of this particular group of workers that the antithyroid therapy has been too vigorous; possibly there is indication of overdosage, and the dosage should be decreased.

Again I should like to mention that there has been only one article in the literature that I was able to find which showed any numerical relationship between the protein iodine values and the dose of thyroid or antithyroid drugs, the one shown on the screen. We have now completed something like 1,400 examinations, and it is my personal feeling that this is the most definitive test available for evaluation of a biologic function.

Approved Substitutes for One Per Cent Silver Nitrate for Prevention of Ophthalmia Neonatorum

The Florida State Board of Health has announced the approval of two preparations to be used by physicians as substitutes for 1 per cent silver nitrate for the prevention of ophthalmia neonatorum.

The substitutes are tetracycline ophthalmic ointment 1 per cent, or equivalent, and erythromycin ophthalmic ointment 1 per cent, or equivalent. Oxytetracycline (Terramycin) and chlortetracycline (Aureomycin) are included.

This action was taken pursuant to authority vested in the State Board of Health by Chapter 383.04 Florida Statutes, which provides that a 1 per cent solution of silver nitrate or other effective prophylactic approved by the State Board of Health be instilled into the eyes of every child at birth.

It should be emphasized that these substitutes for silver nitrate are approved for use only by physicians in hospitals. Midwives and those doing home deliveries are required to use 1 per cent silver nitrate.

Clinical Management of Peripheral Vascular Disease

CHARLES K. DONEGAN, M.D.
ST. PETERSBURG

The whole concept of the treatment of peripheral vascular disease has changed in the last few years. Formerly it was the consensus that there was little or nothing to be done; today much can be done to help the patient with peripheral vascular disease. The management of this group of patients is becoming increasingly important for more people are living longer, and thereby the incidence of arteriosclerosis obliterans is increasing.

Classification

Before discussing the clinical management I will classify briefly the common types of arterial peripheral vascular disease.

1. Raynaud's disease and Raynaud's phenomenon occur more commonly in women than in men. In this vasospastic disorder the extremities are sensitive to cold, and a finger or toe, or several fingers or toes, will frequently turn completely white, and then a deep red color or rubor will follow. Raynaud's phenomenon is much more common than Raynaud's disease and occurs frequently in the absence of arterial disease.

2. Buerger's disease, or thromboangiitis obliterans, is an inflammatory process involving both the small arteries and veins. It occurs more commonly in Hebrews, is more common in men; it may be present at an early age. Frequently gangrenous changes develop on the tips of the fingers and the tips of the toes, and small painful erythematous nodules occur along the course of the veins and arteries.

3. Traumatic arterial thrombosis in the legs is much more common than was formerly realized. Usually no history of trauma may be elicited; however, on examination of the pathologic section of the artery there is no evidence of arterial disease. The patients usually report to the doctor with a history of sudden onset of a cold painful leg, and the condition is frequently misdiagnosed as thrombophlebitis.

4. Last, and probably most important, is arteriosclerosis obliterans.

Read before the Florida Medical Association, Eighty-First Annual Meeting, St. Petersburg, April 4, 1955.

Diagnosis

To make the proper diagnosis and plan the management in a given case a complete history and physical examination and certain laboratory work are necessary. The pertinent points of the history are the age, sex, and ancestory of the patient, duration of symptoms, and particular inquiry about intermittent claudication, which is classically the onset of cramp or ache in the calf or ankle, on walking, relieved by rest. Raynaud's phenomenon is the sudden onset of the fingers turning white with pronounced pallor, followed usually but not necessarily by an extremely red color or rubor. The important point in differentiating Raynaud's phenomenon and Raynaud's disease is the presence of adequate circulation in the phenomenon, and absence of adequate circulation in the disease. Raynaud's phenomenon is much more common than Raynaud's disease. Raynaud's disease and Raynaud's phenomenon usually occur in women and involve the hands as well as the feet. Raynaud's disease and thromboangiitis obliterans, or Buerger's disease, involve the upper extremities, while arteriosclerosis obliterans rarely if ever involves the upper extremities. If there is a history of painful red subcutaneous nodules along the veins, one thinks of Buerger's disease. Changes in temperature are noted in all three disorders, and are spasmodic in Raynaud's disease. Postural color changes occur both in Buerger's disease and arteriosclerosis obliterans, but not in Raynaud's disease. One notes whether or not ulcerations of the fingers or toes have ever been present. Ulcerations are not common in Raynaud's disease, but are common in Buerger's disease in the upper extremities, while ulcerations in arteriosclerosis obliterans are present in the lower extremities. In evaluating the condition of the patient, it is important to know his tobacco consumption.

A complete general physical examination should be performed with special attention to the extremities; the color should be noted with the feet elevated and dependent. In arteriosclerosis obliterans, there is pronounced pallor on elevation of the feet in the dependent position, then decided

rubor, that is, red toes with cyanosis. This change is more commonly present in Buerger's disease and arteriosclerosis obliterans. One notes whether or not the extremities are cold. Palpation for pulsation of the femoral, popliteal, posterior tibial, and dorsalis pedis arteries gives useful information in that the posterior tibial and dorsalis pedis arteries are usually absent in both arteriosclerosis obliterans and thromboangiitis obliterans. Venous filling time gives some information in the diagnosis for normally the vein should fill on moving from an upright position to a dependent position in about 12 seconds.

Helpful laboratory tests are oscillometric studies with either the Collins or von Recklinghausen oscillometer. Oscillometrics give no more information than the physical examination except to provide an objective reading. The use of 1/200 grain tablet of nitroglycerin under the tongue with repetition of the oscillometric studies gives helpful data for in arteriosclerosis obliterans nitroglycerin may cause great dilatation of peripheral arteries, which indicates that Peritrate would be a useful drug in the treatment of this disorder. On the other hand, if there is lack of symmetry of the disease, nitroglycerin actually may reduce blood flow in the bad extremity and increase blood flow into the good extremity. If this result occurs, it is harmful, and Peritrate or nitroglycerin should not be used. Roentgenograms of soft tissue demonstrating calcification of the vessels gives diagnostic assistance. A serum cholesterol test is worth while. A thermocouple is useful only in that it gives objective temperature recordings before and after treatment. Even without a thermocouple patients in whom Priscoline is effective will volunteer that the extremities are definitely warmer, and the change can be readily noted on physical examination. If there is question of traumatic thrombosis, arterial studies are helpful in order to evaluate how much arterial circulation is present and to determine whether or not a graft would be helpful. Arterial studies are much simpler than is realized. Urokon, 10 cc. of a 35 per cent solution, is rapidly inserted into the femoral artery, and an arteriogram is taken just before completion of the injection. This will show whether or not there is a segmental occlusion, give some index of the amount of circulation of the leg, and help in deciding whether or not surgery would be of benefit.

General Measures

In all types of arterial peripheral vascular disease, essentially the same general type of treatment is employed with some variations depending upon the given condition. (1) General foot care consists of : (a) first of all, avoid heat; (b) if the skin is dry, lanolin may be used to lubricate it, or if moist, the periodic use of isopropyl alcohol as a drying agent is useful; (c) care of the nails is extremely important to avoid infection around the nails and ingrown toe nails, for a slight infection under the nails may precipitate an ischemic neuritis; and (d) it is important to avoid constrictions of any type around the leg. (2) The value of Buerger's exercises is controversial, they give the patient something to do, however, and make him more conscious of inadequate circulation in his legs; not that it is particularly good to make patients conscious of their disease, but I think he is more likely to understand that he should take good care of his extremities, and preventive care is of utmost importance in peripheral vascular disease.

It is necessary for the patient to stop smoking in all types of peripheral vascular disease. One frequently hears the statement that in arteriosclerosis obliterans the patient may smoke without harm. This is not true. To stop smoking will give more effective vasodilation than any of the vasodilating substances. Several vasodilators are available at present, and Priscoline is the best. The dosage of Priscoline may vary from 25 to 100 mg. four times a day. A few patients cannot tolerate Priscoline. It may produce itching of the scalp, wakefulness, nausea, vomiting, and palpitations. In severe peripheral vascular disease, the more Priscoline one can tolerate, the better. One may give as much as 100 mg. four times a day. Dibenzyline is another useful vasodilator. First, one tries Priscoline, and if it is not effective, or not tolerated, Dibenzyline may be used in the dosage of 10 to 20 mg. four times a day. If nitroglycerin produces vasodilatation in the affected extremity, Peritrate may be used to advantage. It is my opinion that these drugs are more effective vasodilators than alcohol, although less pleasant to take.

Anticoagulants are useful in sudden thrombotic arterial occlusions for they will prevent downward extension of the thrombosis. It has been suggested that Dicumarol is a vasodilator. In one in whom there is a critical level of circulation in the leg, it will give some assurance that there will not be additional thrombotic episodes. Sympathectomy is of value in the patient in good condition in whom the vasodilators are not effective or who cannot tolerate the vasodilators, and

in a young person with peripheral vascular disease, especially Raynaud's disease and thromboangiitis obliterans. Arterial grafts may be used in segmental thrombotic occlusion above the knee; they are seldom effective below the knee.

Treatment of Common Types of Peripheral Vascular Disease

After the history and physical examination are completed and the diagnosis is made, one may plan the treatment for the patient.

Major considerations in the treatment of Raynaud's disease and Raynaud's phenomenon are: (1) It is most important for the patient to avoid cold and sudden emotional changes. (2) The patient must stop smoking. (3) Priscoline usually gives dramatic relief. If Priscoline is ineffective, the other vasodilators may be used. The patient with Raynaud's disease or Raynaud's phenomenon needs advice and instruction in general measures for the care of the extremities.

In Buerger's disease it is most important for the patient to stop smoking, and anticoagulants are useful to prevent superficial thrombophlebitis. In all patients who have Buerger's disease that is at all active, anticoagulant therapy on a continuous ambulatory basis should be given. Priscoline and the other vasodilators are helpful as well as general measures.

One of the most difficult problems is the treatment of ischemic neuritis. This is most painful, and just touching the toe or touching the patient's bed may set off severe paroxysms of pain in the extremities. One of the most common causes of the onset of ischemic neuritis is local infection, particularly around the toe nails, and usually if this cleared, the ischemic neuritis will improve. Patients with this neuritis should stop smoking. Bed rest is helpful because it reduces the blood requirement for the extremity. Elevating the head of the bed on 6 inch blocks will give the extremity slight increase in blood flow, and it is most important that the patients have Priscoline or other vasodilators to tolerance. Buerger's exercises should be performed. If, however, elevation of the extremity precipitates episodes of pain, then the raising of the extremity should be eliminated and the exercises continued on the level and in a dependent position.

A few years ago it was almost mandatory that an extremity either be amputated or a sympathectomy be performed if superficial gangrene was present. Today, it is known that in many instances this condition may be healed on medical treatment. Infection should be treated with antibiotics, and the area kept debrided well, with the use of alcohol if it is moist and lanolin, if dry. The patient should stop smoking, bed rest with the head of the bed elevated 6 to 8 inches should be ordered, and vasodilators should be used; then superficial gangrene usually will heal nicely without resort to surgery.

The treatment of sudden arterial occlusion is of an emergency nature. If the patient is seen within an hour after the arterial occlusion has occurred, usually the extremity can be saved. The first therapeutic measure is to put a vasodilating substance directly into the femoral artery, assuming the occlusion is in the leg, and papaverine, 1 grain, is probably the best, or Priscoline may be used. Histamine is of little or no value. After Priscoline, in the same needle, I follow with intra-arterial heparin to prevent rapid extension of the arterial occlusion. Then the patient should be given maintenance doses of anticoagulants. If the pain is severe, packing the extremity in ice will relieve it completely in a short period of time. The pack is maintained for 24 to 48 hours and then discontinued unless the pain recurs. Bed rest and Buerger's exercises, omitting the elevation of the extremity, are initiated. Progress is slow, and prolonged hospitalization is required. Any measure, however, that will save an extremity is worth while. It is amazing how little blood it takes to keep an extremity alive.

I left to the last intermittent claudication, which is the most common vascular problem encountered. Patients suffering from this condition can be helped. First of all, they should stop smoking; then they should be instructed regarding Buerger's exercises and properly fitting shoes, and should be given Priscoline or other vasodilators. If they are obese, reduction in weight will give them dramatic improvement in the distance they are able to walk. A low cholesterol diet is desirable if hypercholesterolemia is present, and it is important that they have no constriction about the leg such as garters, or tight girdles.

Conclusion

In conclusion, I would point out that the diagnosis of arterial peripheral vascular disease can in most cases be made in the doctor's office without elaborate laboratory aids. All patients with arterial peripheral vascular disease must first of all stop smoking in order to improve. It is no longer proper to look upon arterial peripheral vascular disease with a pessimistic outlook for med-

ical treatment has much to offer the patient with this disease. Sympathectomy is in certain cases a useful adjunct and not a substitute for the medical treatment of arterial peripheral vascular disease.

501 Eleventh Street North.

Discussion

Dr. C. Frank Chunn, Tampa: I enjoyed Dr. Donegan's address and wish to congratulate him. In opening this discussion, however, I must say that the medical treatment of peripheral vascular disease is somewhat different from the surgical treatment, as I see it. Apparently Raynaud's disease is effectively treated medically by the internist because in my experience the surgeon sees few cases for surgical treatment, if he sees any at all. So apparently the chemical blocks of the sympathetics that are used by the internist are effective, the most prominent one being Priscoline.

In Buerger's disease, the maximum treatment of the extremities probably lies in two categories. One is to stop smoking. In my experience I have never known patients with true Buerger's disease to stop smoking. I have seen several and operated on them, performing various operations from sympathectomy to amputation. I have thought some of them would stop, but eventually they all continued to smoke. A local sympathetic block of the vessels to the extremity involved in Buerger's disease is much better in my opinion than the generalized chemical block by the drugs. At this meeting yesterday Dr. Ochsner showed fairly definitely that chemical block of the sympathetics as a rule dilates the blood vessels generally over the body, lowers the blood volume available to the diseased extremity and actually takes more blood away from the involved part that one wishes to supply with more by sympathetic block or sympathectomy. Buerger's disease can be treated effectively with these two measures, and if one can see the patient through age 50 years, the disease will limit itself and burn itself out. Instituting these two measures early probably will prevent amputations.

Arteriosclerosis obliterans is one of the worst results in peripheral vascular disease. One sees more of this disease as the population is living to older age. The problems it presents in patients who are debilitated and ill otherwise are great. These patients should be treated, along with general measures, by sympathetic blocks to the extremity involved, and if there is any hope or any response to the blocks, they should be subjected to sympathectomy. My results have not been uniformly good in arteriosclerosis obliterans. Amputations still are a problem, and it is my belief that when gangrene is definitely present in any portion of a foot — I do not limit that to the toes — nothing is going to save the patient except an amputation, and I think that the amputation should be above the knee. In midtarsal amputations and amputations below the knee, the wounds have failed to heal; infections have set in, and there is a real hazard of infection with anaerobic clostridia, for even in an otherwise clean extremity, the clostridia will thrive only in ischemic and dead muscle. That is what one deals with, markedly ischemic muscle. As to the sudden onset of vascular arterial occlusion, as mentioned by Dr. Donegan, if the patient is seen in the first hour, I think that embolectomy or thrombectomy of these vessels, if they are above the knee, is the procedure of choice. I have had discouraging results with Priscoline and its allied agents in Buerger's disease and in arteriosclerosis obliterans, and likewise with the intravenous enzymes and certainly so with the anticoagulants.

The Practice of Geriatrics

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Fort Lauderdale

It is a statistical fact that as a nation we are getting older. The increase in population is matched by a disproportionate increase in older people. Now old age is to be reached and enjoyed by the majority instead of the minority. We are faced with the medical paradox that any progress made in the control of chronic diseases, such as tuberculosis, diabetes, hypertension, and heart disease, will result in the further increase in the number of the aged and the problems coexisting with them, especially those due to chronic invalidism.

Early in my practice I realized that a large percentage of my patients were over 60 years old, and that I apparently favored working with them. Recognition of this trend led me to make a deliberate effort to encourage it, so that now over 90 per cent of my practice is with patients over 60 years old. In preparation for this type of practice, I endeavored to delve into special study of those diseases prevalent among the aged. I attended courses and clinics offering this training, read texts and journals devoted to the diseases and problems of the aged and the chronically ill, and became a member of the American Gerontological Society and the American Geriatrics Society. For the past few years I have been affiliated with hospitals and homes for the aged and the chronically ill. Whenever time has permitted, I have participated in community affairs concerned with aging.

The following comments and observations are of note in the practice of geriatrics:

Office

The office should be easily accessible, preferably on the ground floor, and have ample parking area. It should be well lighted, ventilated and

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From the Geriatrics Service of the North Broward General Hospital, Fort Lauderdale, and the Villa Maria Home for the Aged, North Miami.

soundproofed. Waiting is to be avoided, and the staff must be patient and sympathetic.

Records

The records employed vary, depending upon the personnel available and preference by the physician. The following have been found useful:

1. The Cornell Medical Index[1] is not to be used in lieu of a careful history taken by the physician, but rather to supplement it. It is filled out by the patient at his leisure at home, where he will have ample time to review his past and note his symptoms. To this questionnaire may be added a supplement to suit the fancy of the physician who may be interested in a particular phase of the history. On subsequent visits this will be reviewed by the physician, and further information will be added to that obtained previously. This record is especially important since the history is usually long and the memory often short. It is also a medium by which a loquacious or rambling person may be controlled.

2. Physical examination forms are of many types and as detailed as the physician desires, or he may have one printed to suit his needs. The important feature, however, is the thoroughness of the examination and the recording of all findings at the time of the examination so that later variations will be noted.

3. A record of daily activities is probably one of the most important reports submitted by the patient. This also is filled out by the patient at home and will give a reliable account of his activities, physical capacity, recreation, and social behavior, and a comparison of this record with the history previously obtained may show some discrepancies.

4. The patient's notes, which often are brought in at each visit, may reveal many traits, such as a tendency to hypochondriasis, poor memory, tremors or unsteadiness, and at times aberrations in thought. Comparison of notes written later may show changes.

5. Reports and correspondence from physicians, hospitals, and laboratories are important and at times difficult to obtain, especially when a patient has a voluminous history and changes residence or physicians often. For this reason continuity in the record of care may be difficult to obtain. Dr. C. Ward Crampton,[2] repeatedly has advocated the use of a 'life health record' or 'health passport' into which entries would be made by the various physicians of all the medical and surgical illnesses for which the patient received treatment. This record would be carried by the patient and thus be readily available to succeeding physicians.

6. Photographs and recordings are of value in selected cases to show physical changes and alterations in personality.

Evaluating the Patient

The interview with the patient should take place in an atmosphere of complete relaxation, with avoidance of haste and abruptness. It is to be an occasion for mental catharsis by the patient. It is important to evaluate the patient's memory, alertness, concentration, and educational background. The history may be long and confused, often full of inaccuracies and omissions of important events in the medical and surgical experiences. At times one may detect a deliberate coloring by exaggeration, distortion of facts, possibly as evidence of family dissension, resentment, intimidation, or dependency upon others. One must evaluate the effect of environment, economic and social background, and all the work experience. Frequently a patient's description of a symptom may be difficult to evaluate, and only time and patience will make it possible to understand what he is trying to convey.

The physical examination begins when the patient is first seen; note the general appearance, gait, alertness, mannerisms, neatness of dress, assistance in ambulation, use of mechanical aids, and defects in speech, sight, and hearing. It is to be a fact-finding examination, a noting of normal and abnormal findings for the age of the patient. Many old people are reluctant to be examined thoroughly, often requesting that the examination be limited to that part of the body which troubles them at the time. With patience and tact, however, they eventually will relent and permit a more complete study. Included, of course, are to be rectal, vaginal, sigmoidoscopic, laryngeal, and ophthalmoscopic examinations, as required. These should be performed within the succeeding weeks or months, and also all pertinent laboratory and x-ray work. Referral to other physicians or laboratories may be necessary, and great care should be taken to explain the need for such referrals in order that the cooperation of the patient may be assured. The need for a dental survey is to be emphasized. Care should be taken to avoid undue fatigue of the elderly, since some of the diagnostic procedures may tax their physical endurance. Photographs of the patient may be taken, focusing on that part of the anatomy or lesion of interest.

The evaluation of the patient should include all of the body systems, and there are usually multiple diagnoses. Into consideration will come the mental status and the physical capacity of the patient, as outlined by Zeman.[3] They will determine the physical limitations to be imposed upon the patient. Fear and apprehension are to be avoided.

Treatment

The course of treatment and schedule of visits will be outlined to the patient and family. Emphasis will be placed upon the preventive aspects of geriatrics, such as the correction of overnutrition, undernutrition, elective surgical procedures such as herniorrhaphy, repair of rectocele and cystocele, prostatectomy, cholecystectomy, and biopsy or excision of skin or mucosal lesions. Also advice will be offered on the obtaining of proper dentures, orthopedic appliances, hearing aids, lenses, and other aids. It is better to spend a few minutes in explaining organic physiology or function than it is to hasten the patient out of the office with a prescription. Reading matter in the form of pamphlets may be given to patients who may profit by them.

In the care of the aged, it is best to proceed slowly and cautiously. Overtreatment is especially to be avoided. The effects of drugs are noted carefully, and it is good practice to ask patients what drugs they have taken in the past and what have been their reactions. The same caution applies to a new dietary regimen, since intolerance to foods is common. Advice on the preparation of food is important since there may be limitations imposed by poor dentition, decreased secretion by the salivary glands, achlorhydria, gallbladder disease, previous surgery upon the gastrointestinal tract, and other factors. Into consideration must be taken the patient's financial status, since purchase may be limited to the cheaper foodstuffs, especially to a disproportionate amount of starches, eventually leading to protein depletion and vitamin deficiencies. Food fads are discouraged for the same reason. Of special nutritive value are the 'Baby Foods' and the 'Junior Foods' which are available in great variety to satisfy all tastes and varied nutritive requirements. In addition, they have low salt and low fat content. These foods are of great convenience to those who are alone or homebound, or perhaps may be physically incapacitated, and therefore unable to prepare elaborate meals. Some of the 'Baby Foods' may be further diluted with water, milk, or bouillon and thus be used for tubal alimentation.

Appetite may be stimulated by a few ounces of wine or brandy, when not contraindicated, which I believe to be preferable to cocktails or whisky. This will provide extra calories and a feeling of well-being.

The physician may discern misconception of some disease by the patient. A little time devoted to a discussion of the illness often will eliminate confusion and undue apprehension, and may assure the patient's cooperation. This is especially true in discussing hypertension, and the taking of the blood pressure at each and every visit certainly will focus his attention on it.

Elderly patients who are ill with a chronic disease will require medications for long periods of time. For them the cost of drugs and medical care is a real burden, and therefore care should be taken to request only essential laboratory work, and to prescribe drugs of proved merit. Hospitalization is to be advised with discretion, since most hospital insurance plans do not give coverage to the aged and the chronically ill.

The impact of enforced retirement, the loss of dear ones and friends, the progressive loss of physical ability due to the aging process and the onset of crippling disease, all often lead to periods of depression and hopelessness. It requires the greatest tact and patience on the part of the physician to allay fears and direct interest along wholesome lines. The geriatrician should be well versed in technics of physical and social rehabilitation. Those changes which are part of the normal aging process should be explained to the patient in order to help him better understand the limitations imposed upon him.

Surgery in the aged,[1, 5] is becoming increasingly favorable because of improved anesthesia, better surgical technic, the use of antibiotics, and attention to subclinical nutritional deficiencies and supportive therapy. Rehabilitative measures are started soon after an operative procedure or an illness. Since accidents are the third cause of death, it behooves the physician to alert patients to their proneness to accidents, especially those with poor visual acuity, defective hearing, poor gait, or vertigo, and those who use canes, crutches, or other mechanical devices. Waxed floors, scatter rugs, stairs, poor lighting, and like hazards contribute to accidents.

Upon delving into the family's attitude toward the aged member of the household, one may discern a tendency to hopelessness and laissez faire, or lack of cooperation and understanding, and oc-

casionally actual hostility. Patients who have a devoted family seldom seek entrance into a home for the aged, especially when custodial care is the only need.[6] With intelligent cooperation, the relatives may be taught simple nursing procedures, how to administer medications including parenteral therapy, change dressings, and make simple laboratory tests. Their ministrations may be supplemented by the services of the neighborhood visiting nurse. If in addition the patient has frequent visits from relatives and friends, receives religious guidance, and is given some form of occupational interest, then his life becomes well rounded out. He becomes contented and feels loved and wanted, and therefore still a useful member of society. I believe every measure should be taken to keep the oldster in his home and community, and to admit him into an institution only as a last resort, even though the better homes for the aged do provide many comforts and services.

Retirement

Retirement should not be determined arbitrarily by the chronologic age, but rather by the person's physiologic age, which varies greatly among individuals. Retirement should be achieved gradually, possibly by working a few hours a day, or perhaps changing to a lower level occupation requiring less exertion. Simultaneously, interest is to be cultivated in some wholesome hobby or activity which will be engrossing in the later years. Only by such preparation for the later years will the frustration and inactivity which one now finds among the aged be reduced. Medical science has increased life expectancy, but society has decreased the span of occupational usefulness. Geriatric rehabilitation includes not only medical but also social and economic rehabilitation.

Role of the Geriatrician

The geriatrician can render valuable services to the community[6] as a consultant on matters relating to the aged and the chronically ill, such as facilities for their care and housing, home care programs, housekeeper services, rehabilitation, organization of courses on the chronically ill and the care of the aged, foster homes for the aged, and recreation and adult education programs, but above all, he should work with other groups interested in these matters, be they in medical, social, economic or other fields.[7]

Preparation for this type of practice would be facilitated by placing greater emphasis upon the aging process and chronic diseases in the training of the physician. Also, geriatrics divisions and clinics should be established in the larger hospitals and homes for the aged, which would serve as training mediums for interested physicians.[8]

The practice of geriatrics is difficult and time-consuming. There is great satisfaction, however, in the appreciation shown by patients who are grateful for the interest taken in their welfare.

Summary

An outline is presented of the practical aspects of the practice of geriatrics. Observations are made on the problems usually encountered, including the social and economic ones. The relation of the geriatrician to the community is discussed. The need for the establishing of geriatrics divisions and clinics in the larger hospitals and homes for the aged is stressed.

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1955 Medical District Meetings

October 10, District D, Fort Lauderdale
October 11, District C, Lakeland
October 12, District B, Gainesville
October 14, District A, Pensacola

Benign Lymphoid Polyp of the Rectum and Anus Report of a Case

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CORAL GABLES
AND
Maurice Lev, M.D.
MIAMI BEACH

The purpose of this paper is to re-emphasize the importance of recognizing and managing the entity designated benign lymphoid polyp of the rectum, and to present a personal case. The standard proctologic textbooks by American authors either make no reference to this condition,[1-3] or contain short descriptions.[4] The British authors have afforded somewhat more extensive descriptions.[5,6]

In 1951, Helwig and Hansen[7] reviewed the literature on this subject, giving this condition the name of benign lymphoid polyp. They concluded that local excision is a procedure sufficient for cure. Seventy such lesions were collected from the Armed Forces Institute of Pathology, and formed the basis of their conclusions. It is to be noted, however, that their conviction that these were benign lesions was based largely on histologic grounds. Only 12 patients had been proved by a five year or longer follow-up to be without recurrence, though it is said that in no others was it recorded that malignant lymphoma had developed. Li[8] reported 26 personal cases and collected 23 additional cases from the literature. She emphasized the relation and coexistence of these lesions with hemorrhoidal disease and their lack of association with generalized lymphoid neoplasm.

Report of Case

A 46 year old married white housewife entered the Mount Sinai Hospital complaining of hemorrhoids of four and one-half years' duration, beginning in the third trimester of her last pregnancy. Pain was noted the first six months, but the late symptoms were bleeding and prolapse on defecation. In addition, she had noted a decrease in the caliber of her stools, and a groovelike indentation on one side of the stool for approximately six months. The family history was of interest in that one sister had a submucosal rectal nodule excised in August 1953, with a pathologic report of "chronic proctitis and slight hyperplasia in adjacent lymph node." The past history was unremarkable with the exception of a slight gain in weight within the past two years.

On physical examination, positive findings were confined to the pelvirectal examination. On pelvic examination, a 3 cm. mass was felt behind the vaginal wall posteriorly, having a perfectly smooth contour. The rectal and anoscopic examination revealed moderate internal hemorrhoids at 2, 4, 7 and 10 o'clock. A 2 by 3 by 2 cm. polyp was felt attached to the right lateral wall of the rectum at a distance of 4 cm. from the anorectal line. This was freely movable on a short, broad pedicle. No lymphadenopathy was demonstrable in the usual groups of lymph nodes, nor was there any splenomegaly or enlargement of the liver.

A double contrast barium enema revealed no additional polyps above the one in question. Sigmoidoscopy to 20 cm. was performed on March 11, 1954, which revealed slight dilatation of the blood vessels in the submucosa, but otherwise gave negative results until the sigmoidoscope reached 4 cm. above the pectinate line. At this level on the right lateral surface at 4 o'clock in the prone position, there presented a 2 by 3 by 2 cm. deep polypoid lesion with a fairly sessile base. The pedicle measured approximately 1 cm. vertically and 3 cm. horizontally. No fissure or fistula was seen. The polyp presented a rather flattened appearance at the most central surface. There also was noted a cobblestone appearance with mounding in pebbly fashion, such as would be caused by underlying lobulation. The mucosa was slightly deeper pink than the rest of the rectal mucosa with the exception of this central area, where it was yellowish and paler than ordinarily. The preoperative diagnosis was adenomatous polyp of the rectum, and hemorrhoids.

The patient was given spinal anesthesia after the usual preparation and draping, and the polyp was easily deliverable through the anal sphincter following preliminary dilatation. Closer palpation confirmed the impression of local involvement of the submucosa only. The firm nodulations could be felt to be separated from the muscularis propria of the rectum. It was found feasible to apply two small Kelly clamps in a horizontal direction beyond the limits of this nodularity. The polyp was excised by the Bovie knife, the tissue held by the clamps being fulgurated with the coagulating current, and this line of excision was reinforced with a continuous running suture of 00 plain catgut.

The mass was incised by the pathologist in the operating room, and revealed a lobulated greyish pink cut surface with mild mounding of the lobules without definite encapsulation. A frozen section was done, and diagnosed as lymphoid tissue without commitment as to benignancy or malignancy. The hemorrhoidectomy was then performed in the usual fashion, a clamp and suture technic being employed.

The postoperative course was smooth. A medical consultation revealed a normal peripheral blood smear and no evidence of generalized malignant lymphoma.

Pathologic Examination. — Gross Description: The specimen consisted of a greyish pink, polypoid mass, measuring 3 cm. in greatest dimension. The external surface was finely granular. The tissue was semifirm in consistency and, on section, grey and lobulated.

Microscopic Examination. — Sections revealed large intestinal mucosa beneath which the tissue consisted of large and in some cases giant-sized, single and confluent lymphoid follicles (figs. 1 and 2). The reaction centers of these follicles consisted of large lymphoid cells and reticulum cells, while the periphery was made up of mature cells. Many large reticulum-like cells in the centers contained nuclear debris (fig. 3). Fibrous tissue septums subdivided the lymphoid masses and were infiltrated with lymphoid cells. These infiltrating cells were of a benign character. Aside from the germinal centers, mitotic figures were rare. The mucosa was slightly impinged upon,

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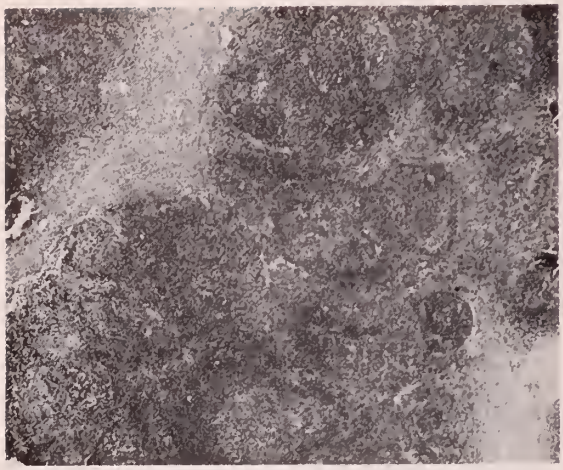


Fig. 1. — General structure of the tumor. Hematoxylin-eosin stain. X24.

but not distorted. Reticulum stains revealed sparse reticulum within the lobules, but considerable reticulum between the lobules (fig. 4).

The pathologic diagnosis was: Benign lymphoid polyp of the rectum.

In summary, this is a typical case of benign lymphoid polyp of the rectum. The patient had a typical hemorrhoidal history with the additional feature of indented stools. A polyp was found in the rectum, which was diagnosed preoperatively as adenomatous polyp of the rectum. Treatment consisted of local excision to be followed by lengthy postoperative observation.

Discussion

Lymphoid polyps of the rectum are by and large indistinguishable from adenomatous polyps of the rectum on gross examination. They present as polypoid lesions, usually under 5 cm. in diameter, which are broad-based, covered by intact and smooth or lobulated mucosa, and on palpation feel firm and finely nodular. They are mucosal or submucosal in depth. The location of these polyps is usually within 3 cm. above the dentate line and rarely as high as 9 cm. They are ordinarily single and discrete, though they have been described as occurring in circumferential distribution as a ring lesion, as well as being present at the tip of a hemorrhoidal mass. On cross section these polyps are grey to pinkish grey, are poorly encapsulated, but nevertheless circumscribed, and are composed of lobules which are discernible grossly, separated by incomplete septums of fibrous tissue. The lobules contain lymph follicles with reaction centers. Histologic examination reveals the lobules to consist of variously sized lymphoid follicles. The germinal centers contain young-appearing lymphoid cells with pale nuclei and an increase of cytoplasm as contrasted to the more mature appearing cells of the remainder of the follicle. Mitotic figures may occur in varying frequency within the germinal centers. Aside from their size and confluency these follicles show no anaplastic features. Large phagocytic cells with ingested cellular debris are often found in the centers. Usually the lymphoid cells do not penetrate through the muscularis mucosae. In isolated instances, however, penetration as far as the muscularis propria of the rectum has been reported, without affecting its benign prognosis.[9,10] Silver stains show considerable reticular fibers between the lobules, but sparse reticulum within the lobules.

The fundamental task for the pathologist is to rule out malignant lymphoma (lymphosarcoma and giant follicular hyperplasia). Lymphosarcomas readily infiltrate the mucosa diffusely, and may show no follicle formation, nor have germinal centers. Mitotic figures are frequent outside germinal centers, and the musculature is invaded. Large phagocytic cells with cellular debris are usually not found. With silver staining a diffuse reticular pattern is found. Most important, however, is the presence of malignant lymphoma elsewhere. Malignant lymphoma of the rectum is not found as a solitary lesion. Of 394 autopsies for generalized lymphosarcoma only 1 showed a polypoid lesion in the rectum, and this was associated with lesions in the sigmoid.[1]

When the follicles are large and not obscured, as in our case, giant follicular hyperplasia must be ruled out. In the latter there are usually no fibrous septums, and phagocytic cells with cellular debris are usually not seen.

The differential diagnosis between the two



Fig. 2. — Tumor in the mucosa. Hematoxylin-eosin stain. X129.

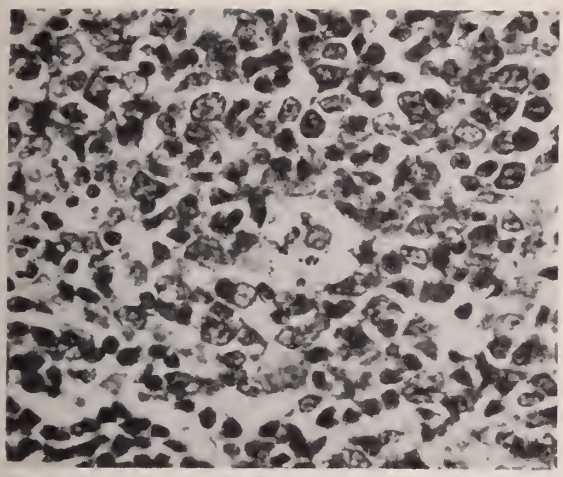


Fig. 3. — Reticulum cells with nuclear debris. Hematoxylin-eosin stain. X720.

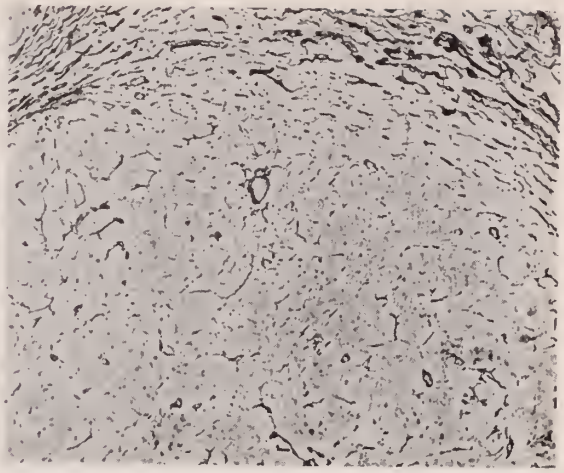


Fig. 4. — Reticulum network in the lobule and in the septum. Reticulum stain. X129.

lesions, however, from the histologic picture alone may be extremely difficult. It is therefore advisable for the pathologist to request the surgeon to look for other manifestations of lymphosarcoma, even when the histologic picture is seemingly typical of benign lymphoid polyp. It is also advisable to watch the excised area periodically for a period of several years for possible recurrence.[11]

Summary

Benign lymphoid polyps of the rectum usually occur within the reach of the examining finger, being grossly indistinguishable from adenomatous polyps.

Although many benign lymphoid polyps of the rectum can be differentiated histologically from malignant lymphoma, it is often difficult to make the diagnosis without clinical consultation.

Malignant lymphoma of the rectum hardly ever occurs as an isolated lesion, whereas benign lymphoid polyp is usually an isolated lesion.

Recommended treatment for benign lymphoid polyp is total biopsy by local excision, with prolonged postoperative observation.

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Dr. Ralph W. Jack of Miami, chairman of the Council of the Florida Medical Association, has announced that the medical district meetings have been scheduled for October 10, District D, Fort Lauderdale; October 11, District C, Lakeland; October 12, District B, Gainesville, and October 14, District A, Pensacola.

Abstracts of Medical Articles

Cell Growth and Dehydrogenase Activity: A Histochemical Enzyme Study of Primary Squamous-Cell Carcinoma of Bartholin's Gland. By Sam Wesley Denham, M.D., and Alvan G. Foraker, M.D., Am. J. Obst. & Gynec. 67:1151-1154 (May) 1954.

The histochemical staining reaction in a case of primary squamous cell carcinoma of Bartholin's gland is presented. The studies on this case were of particular interest in comparison with the histochemical studies on the far more common and clinically important squamous cell carcinoma of the cervix.

This case fulfilled Honan's criteria in that: (a) it occurred in Bartholin's gland, (b) it arose deep in the labium, (c) it was in connection with the gland duct, and (d) it lay in apposition to Bartholin's gland tissue. Further, the skin was intact over the growth. Treatment consisted of a wide Bassett type bilateral groin dissection and vulvectomy.

Histochemical staining reactions were those of a fairly well differentiated squamous cell carcinoma. Small amounts of glycogen were demonstrated in the tumor cells, increasing with cell maturation. The failure of intraepithelial cervical carcinoma to reveal histochemical glycogen-staining reactions is well known. Dehydrogenase activity was found in the neoplastic cells, decreasing with cell maturation. Paucity of glycogen deposition, increasing with cell maturity, and dehydrogenase activity increasing with cell immaturity should also apply to squamous cell carcinoma of the cervix.

Dehydrogenase Activity. I. In the ovary. By Alvan G. Foraker, M.D., Polinestor Aguilar Celi, M.D., and Sam W. Denham, M.D. Obst. and Gynec. 2:407-413 (Oct.) 1953.

The investigation reported here was undertaken for the purpose of studying by a histochemical technic the location of sites of dehydrogenase activity in the human ovary. In ovaries from 27 women, dehydrogenase activity, as manifested by formazan deposition, corresponded closely to areas of conventionally demonstrable cellular growth and activity.

The results of this study of localization of these sites by incubating tissue blocks in neotetrazolium with succinate showed (1) moderate dehydrogenase activity in the stroma; (2) dehydrogenase activity in follicular and theca cells of the developing follicle, increasing rapidly with leutinization; and (3) no evidence of dehydrogenase activity in corpora albicantia. This pattern of dehydrogenase activity correlated with presumed sites of hormone production in the ovary, as well as with more general evidence of cellular proliferation.

Dehydrogenase Activity. II. In the fallopian tube. By Alvan G. Foraker, M.D., Sam Wesley Denham, M.D., and Polinestor Aguilar Celi, M.D. Obst. and Gynec. 2:500-507 (Nov.) 1953.

An investigation is reported in which the localization of sites of dehydrogenase activity within fallopian tubes was studied by incubating tissue blocks in neotetrazolium with succinate. The results showed (1) intense dehydrogenase activity in tubal epithelium, more or less irrespective of other findings in the tubes, or of the clinical setting; and (2) considerable evidence of dehydrogenase activity in inflammatory cells in various types of salpingitis. In 2 cases of chronic salpingitis cholesterol crystals were identified.

Dehydrogenase Activity. III. In the rabbit placenta. By Alvan G. Foraker, M.D., Sam Wesley Denham, M.D., and Dorothy D. Mitchell, A.B. Obst. and Gynec. 4:527-535 (Nov.) 1954.

This report deals with sites of succino-dehydrogenase and endogenous reductase activity which have been histochemically localized in the rabbit placenta at the thirteenth day of gestation. There was little evidence of correlation between such sites and the localization of alkaline phosphatase, lipid, or glycogen. Cytoplasmic evidence of dehydrogenase activity was found in syncytium, trophoblast, periplacental endometrial epithelium, decidua, myometrium, and periplacental endometrial stroma, in approximate order of diminishing strength of staining reaction.

Possibilities of correlation of this enzyme activity with general cell growth or with sites of hormone production are reviewed.

The Phylogenesis and Ontogenesis of Congenital Malformations of the Heart. By Maurice Lev, M.D. Transactions of the American College of Cardiology 3:177, 1953.

In this paper the phylogenetic and ontogenetic development of the mammalian heart is presented as a means of understanding congenital cardiac malformations. The possible variants responsible for the more important malformations are briefly discussed. This discussion reveals that most congenital malformations of the heart can be explained on the basis of arrest in embryologic development or abnormal embryologic development. Only transposition of the arterial trunks is better explained on the basis of a phylogenetic variant.

It is also clear that anomalies may be isolated, or groups of anomalies may be constantly associated. The latter situation is due to one of two reasons. (1) An abnormality in a certain stage of development may lead to another in a late stage of development because of alterations in hydrodynamics produced by the first anomaly. Thus defect of the ventricular septum, patent foramen ovale and patent ductus arteriosus may be secondary hydrodynamic anomalies. (2) Associated anomalies may be due to a basic variant, as in transposition with pulmonary hypoplasia, or transposition with a-v stenosis (abnormal absorption of the bulbus).

In this comprehensive effort to clarify the pathogenesis of congenital cardiac malformations, no ready explanation is offered for isolated pulmonary or isolated aortic stenosis. The author observes that here a healed fetal endocarditis may still be entertained as a possibility even though no adequate proof exists for such a thesis.

The Selective Use of Anticoagulants in Acute Myocardial Infarction Based on Initial Prognosis. By Morton M. Halpern, M.D., Louis Lemberg, M.D., Martin Belle, M.D., and Herbert Eichert, M.D., F.A.C.P. Ann. Int. Med. 41:942-951 (Nov.) 1954.

In this study the prognosis was recorded immediately and 24 and 48 hours after the onset by the examining physician in 117 cases of verified acute myocardial infarction. Fatal termination in 10, or 8.5 per cent, within the first 24 hours of admission left 107 cases to be studied. In 29 per cent of these cases there was a change in prognosis during the first 48 hours, in 6 from "satisfactory" to "poor" with eventual death in 4, and in 24 from "poor" to "satisfactory," with 3 deaths ensuing. Of 82 patients receiving anticoagulants, 15.8 per cent died; of 25 not receiving anticoagulants, 8 per cent died. Among "satisfactory risk" patients as judged at the end of 48 hours the mortality was 5 per cent with or without anticoagulants; in "poor risk" patients it was 25 per cent.

The authors observe that the most significant features in the history which should automatically place the patient in a "poor risk" category are previous myocardial infarction and heart failure. Also, a history of thromboembolism is undoubtedly a bad prognostic sign. Severe shock and acute pulmonary edema are the most ominous signs of the acute attack. Intractable pain may contribute to the shock. The general appearance of the patient also is of great importance. Absent QRS changes in the 12 lead electrocardiogram indicate a "satisfactory" risk, barring the serious signs mentioned or the diagnosis of massive subendocardial infarction. No fatalities among those admitted after the first 24 hours of the attack suggested that a natural selection had taken place in that they probably were not considered ill enough to be admitted to the hospital.

The conclusion from this study was that it is impossible to determine the prognosis of an acute myocardial infarction during the first 48 hours of the attack with enough accuracy to justify the withholding of anticoagulants unless the onset was 48 or more hours previous to the initial observation. In the latter case, enough crucial hours have elapsed to make a safe estimate of the prognosis which, if satisfactory, would justify the withholding of anticoagulants. In all of the other cases it is recommended that anticoagulants be administered initially for at least two days, until a more accurate prognosis can be established. After that the anticoagulants may be withdrawn in those cases in which the prognosis is considered good.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 1018, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

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Keynote of Twentieth Century Medical Progress

Medical historians and philosophers enjoy playing the game of "The Ten Greatest." They indulge with zest in the favorite indoor sport of listing the 10 greatest names, or discoveries, or drugs, in medicine. "The whole subject is fascinating," Dr. Morris Fishbein[1] observed recently, "and the coming generation could have fun and learn a lot by debating it." He then commented editorially on the "tantalizing" list of greatest advances of all time compiled by Dr. Louis H. Roddis,[2] distinguished medical officer of the United States Navy. Included in order were the discoveries of bacteria or other living organisms as causes of infectious disease; smallpox vaccination; the circulation of the blood; anesthesia; the roentgen ray; the transmission of diseases by insects, parasites and other animals; the use of ligature to control hemorrhage; the conquest of scurvy; the stethoscope; and the sulfonamides and antibiotic drugs. Could one fail to list any of these great discoveries? What substitutes, what additions would one make? Dr. Fishbein would recognize the significant place of psychiatry in the medical scheme. And where is Hippocrates, he asks, and the fundamental observations that made medicine a science?

Commenting on the prodigious rate of progress in medicine since the turn of the century, another distinguished medical writer offers a noteworthy explanation in a recent article. Dr. W. Barry Wood Jr.,[2] Busch Professor of Medicine at Washington University School of Medicine in St. Louis since 1942, who this fall becomes vice president of the Johns Hopkins Hospital and University in Baltimore, cites a changed attitude as the most important medical advance of the present century. Greater advances in controlling sickness and pestilence have been made in this "logarithmic phase of medical progress" than in all preceding centuries put together because, in his opinion, a change in attitude of practicing physicians toward medicine as a science has marked this era of unprecedented progress.

This change clearly began in this country in 1910 when the Flexner Report on "Medical Education in the United States and Canada" was published. Although it primarily influenced medicine in the United States, the position of leader-

ship into which this country was thrust by two world wars enabled this report to have a profound effect on world medicine. Dr. Wood quotes a recent survey of medical education: "The Flexner beacon has lighted up a half century of medical progress. It shines brightly today, for this study revolutionized the whole basis for the training of physicians in the United States, and in the decades that followed American medicine shot far ahead of the rest of the world." Dr. Flexner, backed by the Carnegie Foundation, fully exposed the deplorable state of American medical schools, and his scathing criticisms sparked an immediate revolution in medical education. His exposé doomed the numerous proprietary diploma mills of medicine then flourishing and led to the establishment of university medical schools in their stead. This development, with the support of the Rockefeller and other large foundations, wrought a complete change in medical practice in this country and later abroad.

Transformed from an apprentice in a trade to a university student of medical science, the prospective doctor became far less rigid in his thinking and learned to expect new discoveries. What he lost in respect for dogma, he gained in appreciation of scientific evidence. Dr. Wood quotes Alfred North Whitehead, who said in 1941, "One of the most advanced types of human being on earth today, is the *good* American doctor. He is skeptical toward the data of his own profession, welcomes discoveries which upset his previous hypotheses, and is still animated by humane sympathy and understanding." Gone is the reluctance to accept scientific advance. Gone forever is the intellectual climate of medicine that was too frigid to nourish the germs of discovery, that ostracized Semmelweis and ridiculed Pasteur as a charlatan. Gone are the prejudice, the empiricism, the dogma handed down uncritically from generation to generation. The metamorphosis of the physician from the artisan who learned his trade from his elders to the scientist of today may well represent not alone the most important advance of this half century but of many centuries.

The enthusiasm with which the medical profession has accepted and applied the many important discoveries that have flooded the post-Flexner era of medicine needs no recounting here. The benefits of these remarkable advances of the last half century have not yet been fully realized even though they have revolutionized methods of treatment and prevention in many instances. The change in medicine's intellectual climate has swelled the ranks of the discoveries as well as accelerated acceptance of newly discovered facts. The post-Flexner change in medical education has contributed to the source of medical progress as well as to its application by bringing a host of scientifically trained research workers and clinical investigators to labor at the frontiers of medicine.

Future generations who follow Dr. Fishbein's suggestion and debate "The Ten Greatest" cannot afford to overlook Dr. Wood's thesis. The future of medicine and of humanity depends on their cultivation of the attitude that will keep the intellectual climate free for discovery and continued progress.

1. Fishbein, M.: The Ten Greatest, Postgard. Med., 17:426-427 (May) 1955.
2. Wood, W. B. Jr.: Medical Progress Since 1900, International Forum vol. 3, no. 4, in Therapeutic Notes 62:103-106 (April) 1955.

1955 Florida Legislature Passes Four of Six F. M. A. Bills

A summary of how legislation of interest to the Florida Medical Association fared in the 1955 Session of the Florida Legislature points up the key importance of presession activities at the county medical society level. The local support of the members of the component county societies in contacting the senators and representatives from their respective communities, informing them first hand of legislative measures desired and opposed, and explaining to them the reasons for the validity of the position taken has proved the basis for the success obtained. This method of approach has been gratifyingly rewarding and in future promises to be even more so as more assistance is offered at this level.

The Committee on Legislation and Public Policy under the chairmanship of Dr. H. Phillip Hampton, and the Bureau of Public Relations deserve the appreciation of every member of the Association for their preliminary spadework in the preparation of the legislative program and for their efforts to obtain its adoption by the legislature. Studying the needs, coordinating with other organizations and agencies, and reviewing the county society proposals called for the expenditure of much time and labor. The Association's office in Tallahassee, maintained during the entire regular session, was manned by Mr. W. Harold Parham, Supervisor of Public Relations, who car-

ried out his delicate and difficult task in an effective manner.

Of six major legislative proposals, four were enacted into law and two failed of passage. First among the four successful measures was the bill pertaining to Hospital Service for the Indigent. This law, which becomes effective on Jan. 1, 1956, establishes state funds to match county funds for hospitalization of acutely ill indigent persons and carries out the recommendations of the Committee on Indigent Hospitalization appointed by Governor Collins at the request of the Association. This bill was part of the Governor's Legislative Program.

Amendments to Medical Practice Act was the second bill acted upon favorably. This measure eliminates the section of the law which instructed the Board of Medical Examiners to examine graduates of schools of medicine unapproved by the Board who, in its opinion, had engaged in subsequent postgraduate study adequate to make their training commensurate with that of graduates of approved medical schools and colleges. Thus the Board is no longer required to examine applicants other than graduates of Class A schools. Another provision is amendment of the subjects in which candidates are to be examined by changing pathology to surgical pathology and anatomy to applied anatomy, adding pediatrics and eliminating physiology and chemistry. Passage of this bill also removes the requirement for unlicensed physicians employed by a licensed physician to register with the State Board of Health and makes it illegal for a licensed physician to employ an unlicensed physician. In addition, the bill accomplishes statuatory revisions which clarify and correct certain inconsistencies.

The Registration Act, the third measure to become law, requires every practitioner of the healing arts to register with the State Board of Health within 60 days after the issuance of his license to practice, the first registration to be under oath. It also requires the registrant to state the number of his license, the college from which he was graduated, and the date of graduation. *Every medical doctor and every member of the other healing arts licensed to practice in Florida who is already registered will be required to make his next annual registration under oath to comply with the provisions of this law.*

Tax Exemption for Real Estate Owned by Medical Societies was the fourth bill to be passed. It amends the Florida Statutes relating to property exempt from taxation by adding a new subsection which provides that certain real estate of medical societies be exempt.

Failing to pass was the Healing Art Identification Act. It required that every practitioner of the healing arts designate in the professional use of his name the kind, branch and system of the healing art in which he is licensed to practice. In addition, it provided that every clinic or hospital, with the exception of medical hospitals and clinics, designate the kind or system of healing art practiced therein.

The Clinic Bill also failed to pass. This measure defined the word "clinic" as three or more duly licensed physicians associated together for the practice of their profession and prohibited any others from using the word "clinic." It required the branch of the healing art practiced to be designated in the clinic name, and when a specialty service was rendered, its inclusion in the name was mandatory.

Several other measures of particular interest to the medical profession were enacted into law. The Medical Student Scholarships law establishes a scholarship program for medical students and requires that the recipient of such scholarship practice for a certain period of time after graduation in a community needing additional doctors of medicine.

The Teaching Hospital for University of Florida Medical School measure appropriated $8,600,000 to be expended for the construction of a Teaching Hospital in conjunction with the Medical School and Nursing School of the University of Florida.

The Salk Polio Vaccine bill appropriates $500,000. This sum is made available for the purchase of Salk Polio Vaccine for indigent children and expectant mothers.

The Mental Health Council law establishes a Council on Mental Health to be composed of 11 citizens to be appointed by the Governor, six of whom shall be members of the profession concerned with mental health and five of whom shall be chosen from the general public. It appropriates $250,000 for research and training.

Indigent Hospitalization Program Underway

The newly created five member advisory committee to help administer a program of hospital care for indigent persons in Florida held an organizational meeting in Jacksonville in mid-July with the Florida State Board of Health, which it will advise in administering the program. Named chairman of the committee was Dr. H. Phillip Hampton, of Tampa, who had previously served as chairman of a committee on indigent hospitalization appointed by the Governor. The report of that Committee, submitted last February, served as a basis for recent legislation which appropriated $500,000 as the state's contribution to hospital care for indigents for the biennium.

In addition to Dr. Hampton, the committee members are Richard Simpson, Monticello nurseryman, who is the State Road Board representative on the State Turnpike Authority and a former State House speaker; Dr. Edward Jelks, of Jacksonville, a member of the Board of Governors of the Florida Medical Association; Pat Groner, administrator of the Pensacola Baptist Hospital and president of the Florida Hospital Association; and Frank Kelly, Miami attorney.

At this initial meeting the State Board of Health approved the advisory committee's first recommendations. These were to launch the program on Jan. 1, 1956, and meanwhile to notify counties of the law's provisions so that they can appropriate funds. Counties participating in the program will share in the state fund on a per capita matching basis. The new law provides that each county must set up a fund of at least 50 cents per capita for hospitalization of its actually ill indigent persons in order to share in the state grants.

Two classes of persons will be eligible for benefits under the program. They include persons in need of hospitalization who are already on the state welfare rolls, and "persons who after proper investigation, are found able to provide basic necessities for themselves but who cannot meet the cost of medical care — the medically indigent."

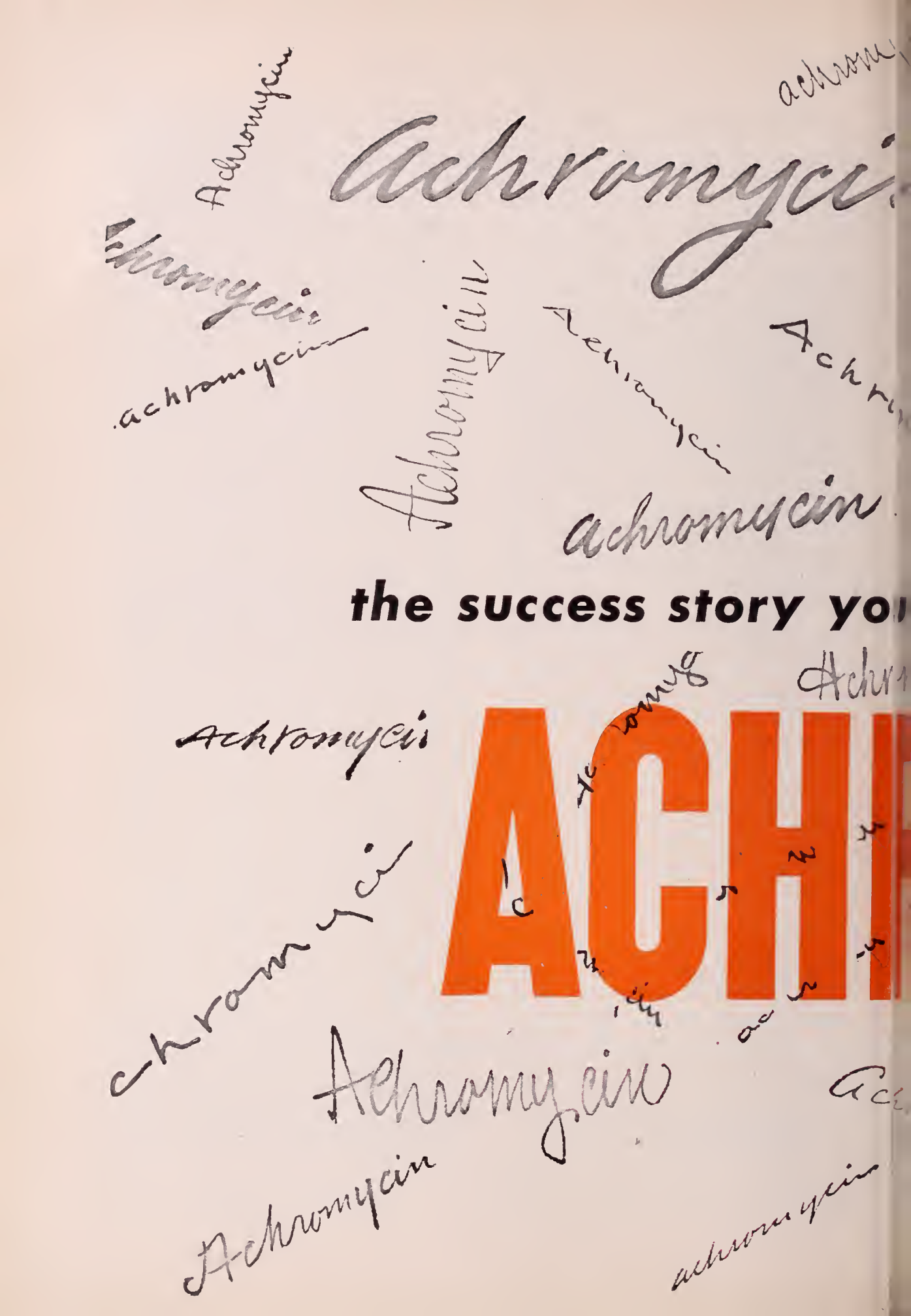
Medical Scholarship Program Advisory Committee Organized

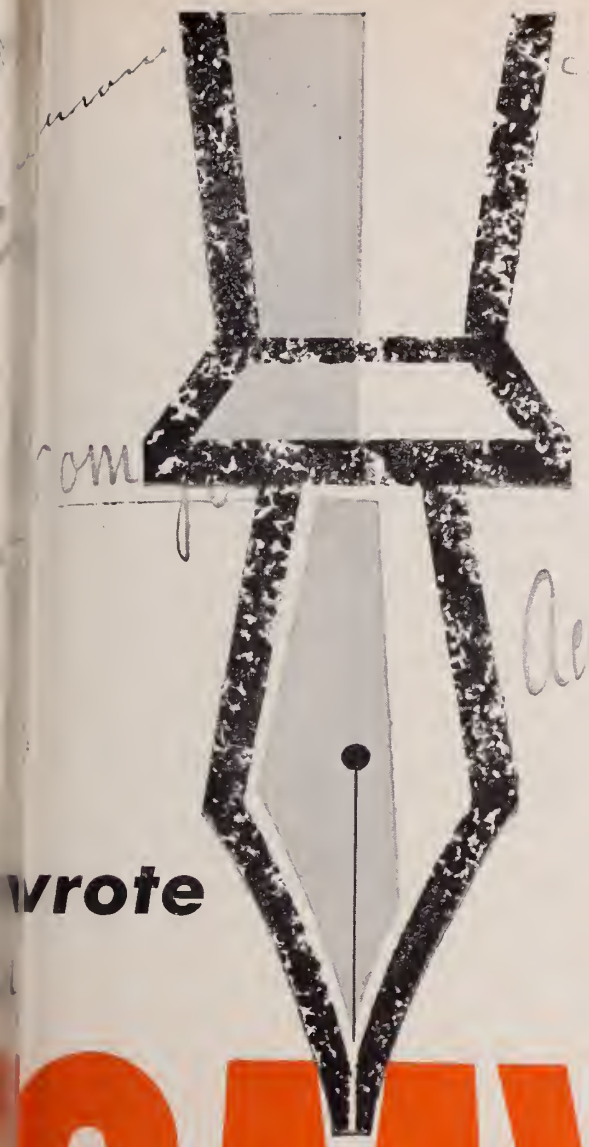
Pursuant to the Medical Student Scholarships bill passed by the 1955 legislature, an advisory committee of five medical doctors appointed by the president of the Florida Medical Association was organized at its first meeting in Jacksonville on July 30. The committee will assist the Florida State Board of Health in administering the medical scholarship training program provided for in the new law. Members of this committee are: Dr. Melvin M. Simmons of Sarasota, chairman; Dr. John D. Milton of Miami, president of the Florida Medical Association; Dr. Homer L. Pearson Jr. of Miami, secretary of the State Board of Medical Examiners; Dr. Turner Z. Cason of Jacksonville, chairman of the Committee on Medical Postgraduate Course of the Florida Medical Association and long identified with the Department of Medicine of the Graduate School of the University of Florida; Dr. James T. Cook Jr. of Marianna; Dr. Homer F. Marsh of Miami, dean of the University of Miami School of Medicine; and Dr. George T. Harrell of Gainesville, dean of the College of Medicine of the University of Florida.

The program provides scholarships up to $1,000 annually for a maximum of four years to 10 qualified Florida students each year for studies leading to a medical degree. Upon graduation, these students will be offered a choice of three Florida communities in need of medical service. The law requires that they serve at least five years in areas approved by the State Board of Health. Other requirements are that the applicant must be a resident of Florida for five or more years before seeking a scholarship, must be able to meet requirements for admission to a medical college approved by the State Board of Medical Examiners, and must furnish proof of inability to pursue medical studies without scholarship assistance. Preference will be given to applicants with highest scholastic averages in undergraduate colleges. This bill became part of Governor Collins' Legislative Program after he had consulted with the Florida Medical Association as to its desirability.

The advisory committee plans to work closely with the state agency in implementing this program. The twofold objective is to assist deserving Florida students and to provide physicians for the smaller communities of the state. Application forms may be obtained by writing the Medical Scholarship Committee, Florida State Board of Health, Box 210, Jacksonville.

(Editorials and Commentaries Continued on page 212)


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Practical Program of Public Relations Five Major Aspects

III. Information and Education

The doctor is a specialist in people. In this role the successful clinician exemplifies the dignity of medicine, which is closely akin to the essential dignity of man. Daily he recognizes the individuality and personality of his every patient; this tribute to the dignity of man is reflected back to him in the high regard his patients have for the ultimate dignity of medicine. He encounters fear — fear of cancer, fear of heart attacks, a thousand and one fears that plague the minds of his patients. He encounters resentment. Illness disrupts; it is unpleasant; it is dangerous and may threaten life; it is not planned for; it is expensive. He encounters ignorance, misinformation, and often a surprising lack of information even among the highly intelligent and well educated.

As counselor, the physician has a remarkable opportunity to combat the fears, the resentments and the lack of health information which beset the general public. In his office, at the bedside, through health forums, radio programs, television shows and emergency services he is privileged to alleviate fear of dreaded diseases and sudden illness, to disseminate helpful information and to educate the people in health matters. At the national and the state level his medical associations through their public relations bureaus disseminate both scientific news and socioeconomic information through correspondence, press releases, special articles and brochures, radio, television, and contacts with other organizations. With the general public, however, these impersonal organizations do not have the influence that the trusted family physician has. To the people, he is the ultimate in public relations.

Witness the medical forums. Their immediate acceptance illustrates how avidly today's increasingly health-conscious public seeks authoritative health information presented in person by the community's own physicians. These health forums, jointly sponsored by newspapers and medical societies, had their inception in Florida as the brain child of Dr. N. Worth Gable of St. Peterbsurg and Stan Witwer, the city editor of the St. Petersburg Times. The cooperation of the Pinellas County Medical Society and the public made this educational method an instantaneous success which continues to prove popular throughout the nation.

This somewhat spectacular personal approach is but one of six major effective methods advocated by the Bureau of Public Relations of the Florida Medical Association in its comprehensive program carefully designed to promote the best medical care for all the people. This program recognizes the individual physician as Mr. Public Relations himself and considers the county medical society the bedrock upon which the program succeeds or fails. The Bureau helps the county society in innumerable ways to build up a constructive public relations program properly coordinated with the Association's program and that of the American Medical Association. It is prepared to establish a complete program within the county society or to assist in any phase of the work the individual county society may desire.

A second leading method of approach is feature articles in the public press informing readers of organized medicine's role in meeting the health needs of each and every community. The written word in this form attracts a wide reader public. Radio and television programs, both live and recorded, constitute a third method which commands even greater response. The spoken word by radio has long had tremendous appeal, and now educational TV is the popular slogan. The trend today is definitely toward a wider utilization of television by medical societies to present a positive picture of American medicine and further health education. In fact, building good television relations is as important to a medical society as establishing good press relations. Some societies use A.M.A. films for television showings or rely on production helps, but many are pioneering in the preparation and presentation of locally produced medical shows. Physicians of Florida and of the nation are to be commended for the aplomb with which they have accepted the challenge of this new tool for health education. Press-radio-television conferences and codes of cooperation provide a fourth important method of approach. They contribute greatly to mutual understanding.

Active speakers' bureaus, a fifth successful measure, have brought to light much latent public speaking talent among the medics. While radio and television appearances draw much larger audiences, addresses by physicians to the various lay groups at their meetings is peculiarly rewarding, for nothing quite equals this particularly personal approach devoid of microphone and floodlights.

Fair exhibits and displays, the sixth of the leading methods of promoting information and education, have won special acclaim in Florida. Some have traversed the state during the winter fair and tourist season and have attracted an audience from across the nation. The ingenuity, skill and effort which members of the Association have put into these endeavors are a notable example of how well today's busy physician accepts his responsibility for the health education of the public. Too, Florida was the scene of the first health fair to feature a Clinical Meeting of the American Medical Association. At the December 1954 meeting in Miami the concluding event was a four day Health Fair for the Public conducted under the auspices of the Dade County Medical Association in collaboration with the American Medical Association and the Florida Medical Association. The outstanding success of this first venture heightened greatly the demand for health fairs and exhibits under medical sponsorship at all levels as an excellent means for carrying out effective health education.

The role of the doctor in disseminating health information and promoting health education for the general public emphasizes his great need for versatility, mentioned last month in the second of this series of five editorials on the Association's practical program of public relations. The best public relations contacts for the physician naturally are made in his office. So great are outside demands, however, that public speaking and educational psychology become likely candidates for the medical curriculum of the future. Meanwhile, the Bureau of Public Relations stands by to serve the Association as a clearing house for aid to the component county societies in all the various phases of educational and promotional work, as coordinator of a sound and sensible program, and as interpreter of the progress in public relations which is attained only by the achievements of the physicians themselves.

Graduate Medical Education
Diabetes Association
October 20-21

The Florida Clinical Diabetes Association will hold its third annual meeting at the Princess Issena Hotel in Daytona Beach on October 20 and 21, 1955. This meeting immediately precedes that of the Florida Academy of General Practice, which is to be held at the same hotel on Saturday and Sunday, October 22 and 23.

Florida physicians participating in the program of the Diabetes Association are Dr. Fred Mathers, of Orlando, Dr. Egbert V. Anderson, of Pensacola, Dr. George C. Austin, of Miami, and Dr. Samuel M. Wells, of Jacksonville. Dr. Joseph T. Beardwood Jr., of Philadelphia, who gave the lectures at the annual meeting last year, will return. He was well received, and all of his lectures were most informative. A new lecturer on the program this year is Dr. Franklin H. Epstein, Assistant Professor of Medicine, Yale University School of Medicine, New Haven, Conn. Dr. Epstein is particularly interested in diabetes mellitus. Both of these guest speakers will address the Academy of General Practice on Saturday, October 22.

Two panels will be held during the meeting, one on Thursday afternoon and one on Friday afternoon. Both of these panel discussions will be directed toward the management of the diabetic patient.

The program in detail will be announced in the October issue of The Journal of the Florida Medical Association, and programs will be mailed to all physicians in the state early in September.

The Judicial Council
A.M.A. Court of Last Resort

Almost a century ago, in 1858, the first permanent judicial body of the American Medical Association, the Committee on Ethics, was appointed. Fifteen years later, the Judicial Council replaced the committee and since 1873 has continued to be that association's court of last resort. Its five members are elected by the House of Delegates on nomination of the president for terms of five years. As defined by its constitution and by-laws, the Council's jurisdiction includes consideration of (1) ethical and constitutional controversies, (2) questions relating to membership and (3) disputes arising between members or members and their medical societies.

At the present time, a distinguished member of the Florida Medical Association, Dr. Homer L. Pearson Jr., of Miami, is chairman of the Judicial Council. For years Dr. Pearson represented the Association in the House of Delegates of the American Medical Association. His elevation to the supreme judicial body of that organization and to its chairmanship brings high honor to this Florida physician, in which his state association takes pride.

At the suggestion of the Judicial Council, Edwin J. Holman, its executive secretary, has transmitted to state medical journals a copy of the Rules of the Judicial Council with the timely request that they be reproduced. Undoubtedly, members of state medical associations will welcome the opportunity to familiarize themselves with the rules of this high court of medicine.

Rules of the Judicial Council
American Medical Association

RULE I. ADMINISTRATION.

A. *Meetings.* The Judicial Council will meet during the Annual and Clinical Sessions of the American Medical Association. Other meetings of the Council may be called, on reasonable notice, by the Chairman of the Council; or they shall be called, on reasonable notice, by the Secretary of the American Medical Association on the written request of at least three members of the Council.

B. *Chairman.* The Judicial Council shall elect from among its members a chairman and vice-chairman each year at the meeting of the Council held during the Annual Session of the Association. Each shall retain the right to vote on all matters.

C. *Quorum.* Three members of the Judicial Council shall constitute a quorum but a majority vote of the entire Council shall be required to adopt any action.

RULE II. APPLICATIONS FOR MEMBERSHIP.

A. *Active, Associate and Service Membership.* Applications for active, associate or service membership in the American Medical Association will be considered by the Judicial Council at any meeting upon presentation of the applications by the Secretary of the Association.

B. *Affiliate Membership.* Applications for affiliate membership submitted by physicians who are members of the chartered national medical societies of foreign countries adjacent to the United States or by American physicians who are located in foreign countries and engaged in medical missionary and similar educational and philanthropic labors will be considered at any meeting of the Judicial Council on presentation of the applications by the Secretary of the Association. The Council will consider and approve only those applications which are accompanied by a statement of a responsible and qualified individual attesting to the above set forth requirements.

C. *Refusal of Approval.* An applicant for membership in the American Medical Association whose application has not been approved by the Judicial Council will be promptly notified of such fact, and will be given twenty days within which to request reconsideration of his application in accord with the provisions of Rule III.

RULE III. RECONSIDERATION OF APPLICATIONS FOR MEMBERSHIP.

A request for reconsideration of a refusal to approve an application for membership should be initiated by a written statement setting forth the reasons for reconsideration.

RULE IV. ORIGINAL CONTROVERSIES.

Original proceedings before the Judicial Council shall be initiated by a written statement. Such statement shall include information (1) identifying the parties to the controversy, including membership affiliations, if applicable, and (2) explaining the nature of the controversy, setting forth the provisions of the Constitution, Bylaws, Rules or Principles of Medical Ethics concerned.

RULE V. APPEALS.

Appellate proceedings before the Judicial Council shall be initiated by a written statement of appeal. Such statement shall include information (1) identifying the parties to the case and indicating membership affiliations when appropriate, (2) showing that the appellant has exhausted remedies made available by the constitution and bylaws of the component society and the constituent association and (3) describing the error of law or procedure which is believed to have occurred during the proceedings. The statement shall also include a concise, factual résumé of the case. Appellant shall submit with the statement the charges, complaints, findings, opinions and decisions previously entered in the case.

RULE VI. INTERPRETATION OF THE CONSTITUTION, BY-LAWS, RULES AND PRINCIPLES OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION.

A. *Requests for Interpretation.* Requests for interpretation of the Constitution, Bylaws, Rules or Principles of Medical Ethics of the Association shall be in writing and shall describe the matter to be interpreted in sufficient detail to enable the members of the Judicial Council to evaluate the request in all its aspects.

B. *Interpretations Initiated by the Council.* The Judicial Council, on its own motion, may render an opinion concerning the interpretation or application of the Constitution, Bylaws, Rules or Principles of Medical Ethics of the Associa-

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The usual adult dose is one rounded teaspoonful of Metamucil powder in a glass of cool water, milk or fruit juice one to three times daily. An additional glass of liquid may be taken if indicated.

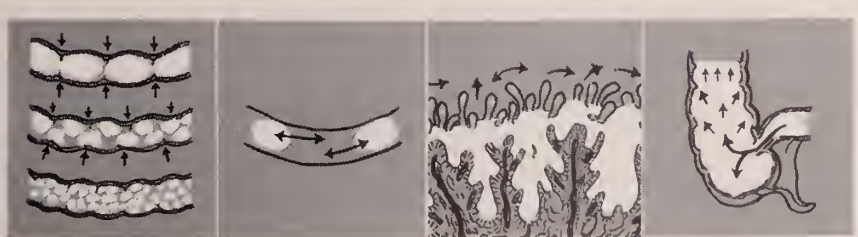
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tion and may, on its own motion, consider and decide the constitutionality and validity of all rules and regulations adopted by Councils and Committees of the Association pursuant to the Bylaws of the Association.

C. *Discretionary Power.* The Judicial Council may, in its discretion, refuse to consider requests for interpretation of the Principles of Medical Ethics which in the opinion of the Council should be resolved by a component society or a constituent association. Requests for interpretation of the Principles of Medical Ethics which are not of national interest and relate to the observance of local customs and ideals may be readdressed to the component society or constituent association primarily responsible for knowledge of the requirements of such local customs and recognized ideals.

RULE VII. JURISDICTION.

The Judicial Council may, on its own motion or on the motion of any party, determine the question of jurisdiction at any stage of the proceedings.

RULE VIII. ADDITIONAL STATEMENTS AND RECORD.

After a statement has been submitted to the Judicial Council with the intention of initiating an action, all other parties in interest shall have the right to submit a statement on their behalf. Such statements shall be filed within thirty days after the filing of the initiating statement unless additional time is granted by the Council.

The Judicial Council may thereafter require the parties to submit such transcripts of testimony, records, written statements supporting their contentions or other material as the Council may deem necessary.

RULE IX. HEARINGS.

A. *Notice of Hearings.* The Council may, in its discretion, determine whether a hearing is necessary or advisable. The Council will designate the time and place for all hearings, giving reasonable notice thereof to all parties.

B. *Attendance.* The attendance at hearings may be limited to the members of the Judicial Council, the staff, witnesses, if any, the parties

(Continued on page 219)

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Optimal dosage proved to be one envelope (7 grams) of Knox Gelatine administered daily for three months. Improvement, however, was noted after the first month. If you would like more complete details of this work, just use the coupon.

1. Rosenberg, S. and Oster, K. A., "Gelatine in the Treatment of Brittle Nails," *Conn. State Med. J.* 19:171-179, March 1955.
2. Tyson, T. L., *J. Invest. Dermat.* 14:323, May 1950.

Chas. B. Knox Gelatine Company, Inc.
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Johnstown, N. Y.

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YOUR NAME AND ADDRESS

(Continued from page 216)

and counsel, who may speak in their behalf. Should any party to the controversy fail to appear, the Council may, in its discretion, continue, dismiss or decide the matter.

C. *Evidence and Argument.* The Judicial Council will not be bound by technical rules of evidence usually employed in legal proceedings but may accept any evidence it deems appropriate and pertinent.

In any appeal case the review, if any, of the evidence will be limited to the evidence presented in the proceedings before the component society and constituent association or appropriate committee, board, or group thereof; provided, however, that in the event the Council is of the opinion such evidence is inadequate to determine the question of law or procedure presented, the Council, on its own motion or on the suggestion of any party, may require the production of additional evidence before the Council or refer the matter to the appropriate body for additional evidence.

In matters other than appeal cases, the Judicial Council will grant the parties the right to present evidence to the extent the Council believes appropriate to the particular matter in controversy.

In all hearings, the Council, within reasonable limitations, will allow oral argument.

D. *Record.* In hearings of original controversies, appeals and in other proceedings a transcript may be made at the discretion of the Council.

Rule X. Opinions.

All opinions or decisions of the Judicial Council shall be in writing. Copies of the opinion or decision and the dissent, if any, will be filed as a part of the record and furnished to all the parties involved.

Rule XI. Filing and Copies.

Eight copies of all documents shall be submitted to the Executive Secretary of the Judicial Council. One copy of each document shall be submitted at the same time to each of the other parties to the controversy.

(Adopted by the Judicial Council of the American Medical Association, October 1, 1954.)

Members of the Judicial Council are Homer L. Pearson Jr., *Miami, Fla., chairman;* Louis A. Buie, *Rochester, Minn.;* Walter F. Donaldson, *Bakerstown, Pa.;* J. Morrison Hutcheson, *Richmond, Va.,* and George A. Woodhouse, *Pleasant Hill, Ohio.*

Ex officio members are George F. Lull, *Chicago, secretary;* Ernest B. Howard, *Chicago,* and Austin Smith, *Chicago.*

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OTHERS ARE SAYING

A Measure of Greatness

The mutual affection between patient and physician is one of Medicine's great rewards. Sometimes patients carry this affection a bit far. It may then be called "transference." This means that the intensity of the patient's emotional attachment to his doctor has become unreasonably strong. We are told by our colleagues in psychiatry that, by this means, one may compensate for an inability to face up to the stress of one's situation.

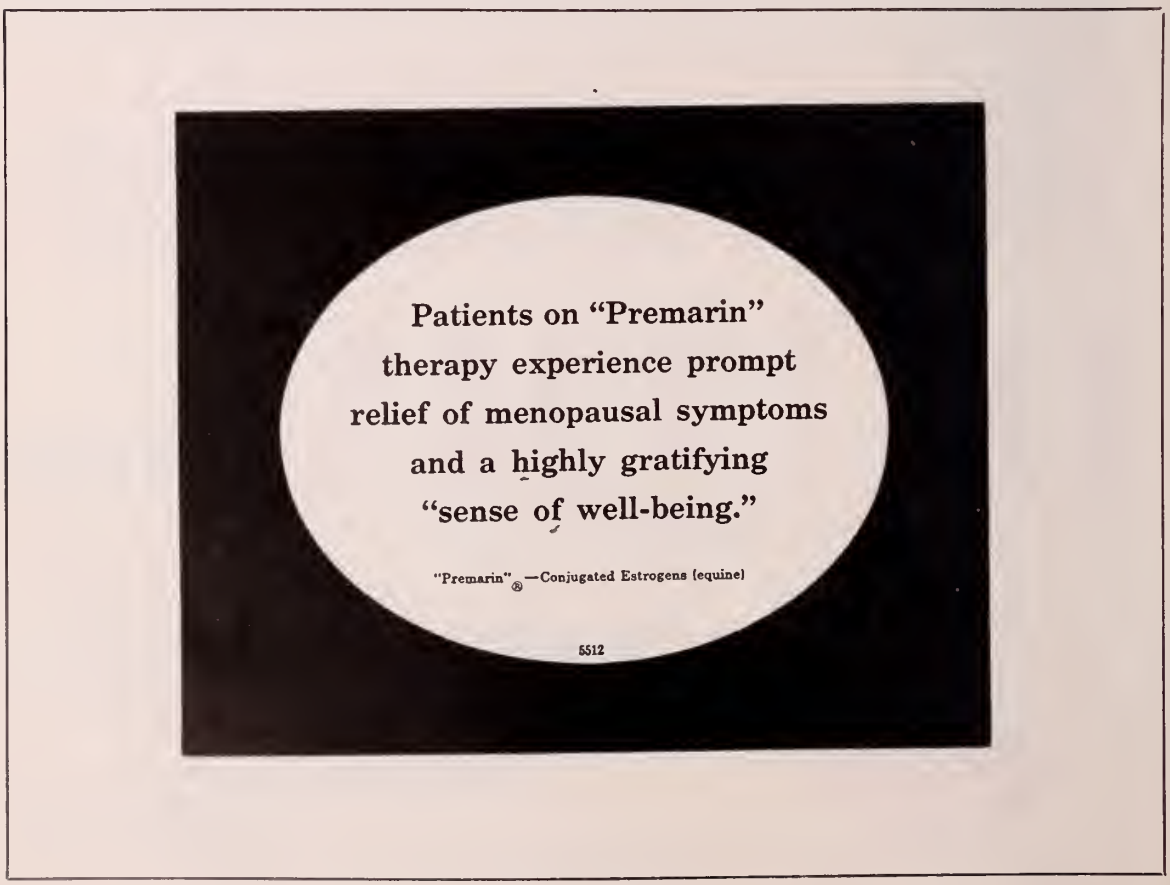
All physicians, even the most unseemly ones, have experiences of this sort. In general, they react in admirable fashion. The doctor resists the patient's attempt to deify him; the personal-emotional-professional relationship is preserved in nice balance; when the patient is ready to try his wings, he is pushed out of the nest — kindly, but resolutely. This is good. It keeps the physician in proper proportions; like son Jack,

". . . a plain-looking lad;
He is not very good,
Nor yet very bad."

Recently a group of psychiatrists interviewed 32 patients before and after cardiac surgery. Most of them were young people, aware and fearful of their progressive physical deterioration.

When surgery was successful, it was not unusual for the patient to see the surgeon with new eyes. He became a "mother," a "giver of new life," a "miracle" worker, a "divinely guided father figure," etc. Perhaps such a reaction is not too extravagant, when one takes into account the magnitude of this change in a despairing patient's vital prospects.

Profound changes in longevity and mortality continue, and indeed will increase as dramatic procedures of this kind become more widely available. With this broadening of medical accomplishment, more than ever will humility be the measure of a physician's greatness.—*G P, April 1955*





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STATE NEWS ITEMS

Dr. Charles D. Akes of Boynton Beach was principal speaker at a recent meeting of the Delray Beach Lions Club. He discussed the Salk vaccine.

Dr. Patrick J. Lynam has returned to Cocoa from Boston where he has been doing graduate work in eye surgery.

Dr. Alfred P. Seminario of St. Petersburg is scheduled to return from Europe the early part of September. He has been visiting various clinics in several countries abroad.

The Medical Advisory Committee to the Florida Council for the Blind met in Tampa July 9-10, 1955. The physicians in attendance were Nathan S. Rubin, Pensacola, chairman; Charles C. Grace, St. Augustine; Carl S. McLemore, Orlando; William Y. Sayad, West Palm Beach; Kenneth S. Whitmer, Miami, and Sherman B. Forbes, Tampa, who was host to the group. Dr. Shaler Richardson, Jacksonville, the remaining member of the Committee, was unable to be present.

More than 1,000 persons gathered in Bowling Green July 4 for an Independence Day celebration in honor of Dr. Wesley S. Pyatt who has been practicing in the community since 1917. Program for the day included speeches, fireworks and a barbecue.

Dr. Allen E. Kuester of Cocoa attended a recent pediatric seminar held at Saluda, N. C.

Dr. William D. Sugg of Bradenton has returned from a trip to Europe and the Middle East. He was one of the speakers at the recent meeting of the International College of Surgeons held at Geneva, Switzerland. Late in July he related some of his experiences aboard to a meeting of the Sarasota Kiwanis Club.



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Methscopolamine bromide 2.5 mg.

Average dosage (ulcer):
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Each 5 cc. (approx. 1 tsp.) contains:
Methscopolamine bromide 1.25 mg.

Dosage:
1 to 2 teaspoonfuls three or four times daily.

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Dr. James G. Wilson, professor of anatomy at the University of Cincinnati, has been chosen to head the anatomy department of the College of Medicine of the University of Florida. His appointment became effective September 1.

Members of the Florida Medical Association who plan to attend the clinical session of the American Medical Association being held at Boston November 29-December 2 have been invited to the annual meeting of the Puerto Rico Medical Association December 6-7. A special Caribbean Air Cruise has been arranged for the trip. The flight is scheduled to leave Boston late the afternoon of December 2. Members interested in the cruise should contact the International Travel Service, Inc., Palmer House, Chicago 3, Ill.

The House of Delegates of the American Medical Association has expressed sincere appreciation to the Florida Medical Association and the Dade County Medical Assoication for an enjoyable 1954 A. M. A. clinical session which was held at Miami. The action of the House followed the introduction of a resolution by Dr. Reuben B. Chrisman Jr. of Miami in which gratitude was expressed for the opportunity of entertaining the A. M. A. clinical session.

Dr. Lowrie W. Blake of Bradenton was principal speaker at a recent meeting of the Licensed Practical Nurses of Manatee County.

Dr. Herman K. Moore of Key West has returned from Vienna, Austria, where he took a postgraduate course in surgery at the University of Vienna.

Dr. Anthony C. Galluccio of Hollywood went abroad late in June where he was scheduled to attend a medical meeting in Paris.

Dr. Morton M. Halpern of Miami was principal speaker at a recent meeting of the Heart Assoication of Greater Miami. At the conclusion of Dr. Halpern's address, Dr. Paul N. Unger of Miami Beach was installed as president of the Association.

Dr. Louis E. Pohlman of Orlando, chairman of the Committe on Blood of the Florida Medical Association, was in Atlanta late in July where he

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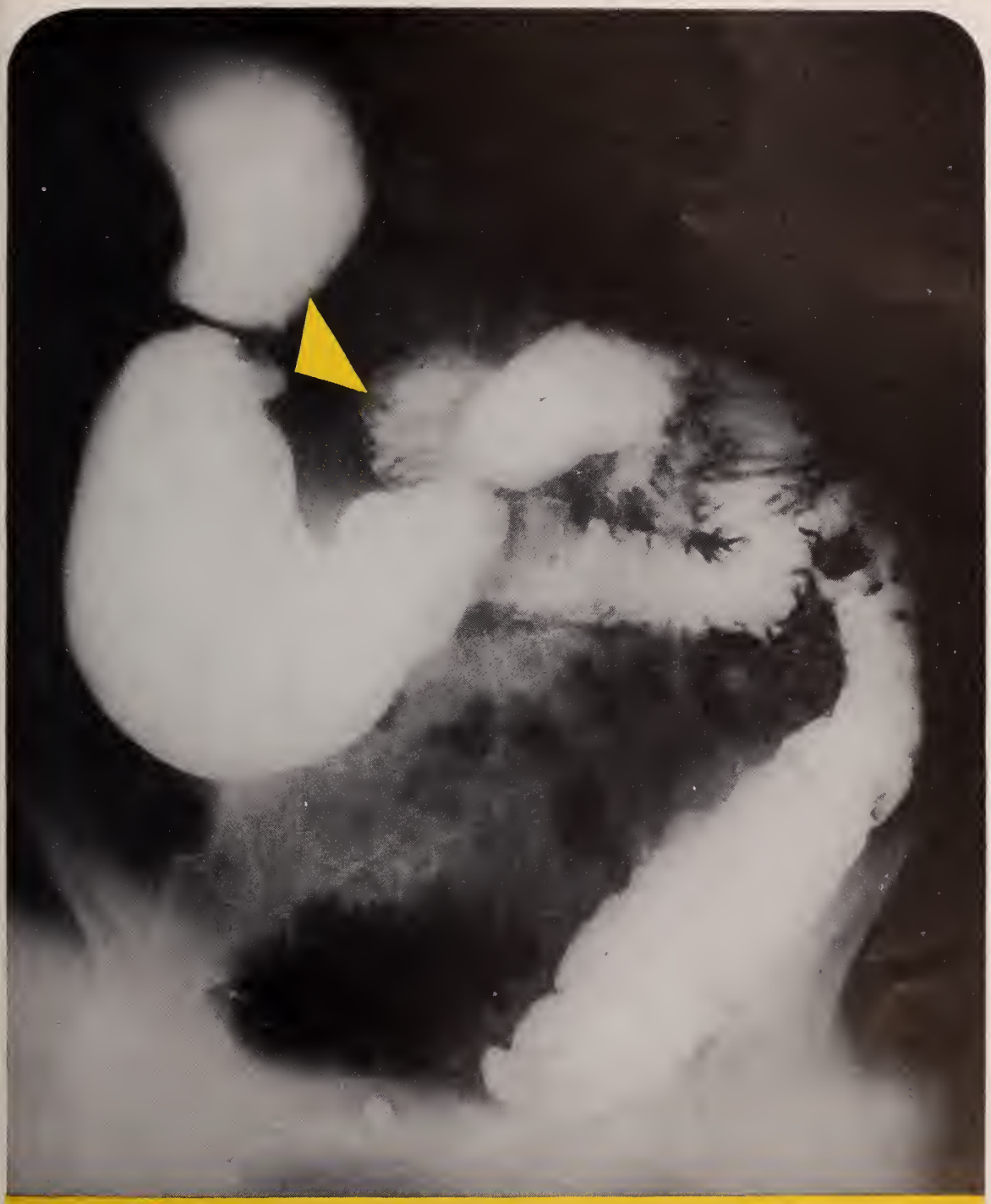
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attended the organizational meeting of the Southeastern Blood Banks Clearing House Association in which Florida is included. Dr. Pohlman was elected temporary president of the new Association. Charter and by-laws are to be adopted at the next meeting being held in Atlanta on September 24.

Dr. Sherman B. Forbes of Tampa addressed the Tri-County Insurance Adjusters meeting at Tampa the first of July. This group includes adjusters of Pinellas, Hillsborough and Polk counties. Dr. Forbes' subject was "Industrial Ophthalmological Problems."

Dr. Robert C. Piper of Miami has returned from Chicago where he recently completed a postgraduate course.

Dr. Edward W. Cullipher of Miami attended the annual meeting of the American Orthopedic Association held at White Sulphur Springs, Va.

The 24th Venereal Disease Postgraduate Course for physicians sponsored by the University of Chicago and the Public Health Service will be given at the University of Chicago, September 26-30, 1955. No tuition will be charged. Applications should be sent to the Section on Dermatology, Department of Medicine, University of Chicago, Chicago 37, Illinois.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Burroughs, Lyle W., Tampa
Cooney, James F., West Palm Beach
Nicholson, John B., West Palm Beach
Schnauss, Wm. R., Jacksonville

COMPONENT SOCIETY NOTES

Lake

Dr. Joseph L. Hundley of Orlando was guest speaker at the July meeting of the Lake County Medical Society. His subject was "Everyday Problems in Dermatology."



Abdominal tenderness

—usually confined to the lower quadrants and at times found only over the cecum—is the most frequently appearing physical manifestation of amebiasis.[1]

KOHN[2] gives a simple, quick method for identifying Endamoeba histolytica in the feces. A small amount of feces is first dispersed in saline solution. If the feces are formed and amebic cysts are likely to be present, solution 1 is used (1 cc. liquefied phenol, 0.6 cc. glacial acetic acid and 50 cc. distilled water). When feces are fluid and vegetative forms are suspected, solution 2 is substituted (0.9 cc. liquefied phenol and 50 cc. distilled water). Two or three drops of the proper reagent are placed on the slide and a loopful of the feces-saline dispersion is added; a cover-glass is applied. The solutions afford a rapid means of differentiation by changing the refractive index of the cells. When the reagent for identifying cysts is used, chromatoid bodies in the cells stand out clearly as rods, bars or short spindle-shaped bodies. Solution 2 outlines details of the nuclear structure, vacuoles and ingested material in the trophozoites.

● ***For nondysenteric colonic amebiasis*—MILIBIS®**

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brand of glycobiarsol and chloroquine, respectively.

1. Martin, G. A., Garfinkel, B. T., Brooke, M. M., Weinstein, P. P., and Frye, W. W.: *J.A.M.A.*, 151:1055, Mar. 28, 1953.
2. Kohn, J.: *Jour. Trop. Med.*, 53:212, Nov., 1950.
3. Information Please: *GP*, 4:91, Sept., 1951.

OBITUARIES

Robley D. Newton

Dr. Robley D. Newton of Fort Myers died of a stomach ailment on April 4, 1955, at Lee Memorial Hospital in that city. He was 84 years of age.

Born in Monroeton, Pa., in 1870, Dr. Newton received his medical training in his native state. He was awarded the degree of Doctor of Medicine by the Medico-Chirurgical College of Philadelphia in 1896 and later taught in his alma mater for some years.

In 1925, Dr. Newton came to Fort Myers, where he engaged in the general practice of medicine for a quarter of a century. He attended Thomas A. Edison when he was in residence there and was a developer of Edison Park. Dr. and Mrs. Newton celebrated their fifty-second wedding anniversary last January. Both were strong supporters of the Moral Rearmament Movement. They moved to Fort Myers Beach in 1936. He was an honorary member of the Fort Myers Rotary Club.

Dr. Newton was a member of the Lee-Charlotte-Collier-Hendry County Medical Society. He had held membership in the Florida Medical Association for 24 years and was also a member of the American Medical Association.

Surviving in addition to the widow are one son, James D. Newton, and one daughter, Mrs. Mary Geddes, both of Fort Myers. Other survivors include two grandchildren, Miss Robley Geddes, of Fort Myers, and Mrs. Nina Geddes Greech, of Belle Glade, and a great granddaughter.

Ben Hill Lawson

Dr. Ben Hill Lawson died at his home in Winter Garden on March 28, 1955. He was 72 years of age.

Born in Colquitt County, Georgia, on Oct. 31, 1882, Dr. Lawson was the son of the late Mr. and Mrs. Henry Briggs Lawson, pioneer Georgians, who moved to Hahira, Ga., when he was two years old. He received his medical training at the Atlanta College of Physicians and Surgeons, now



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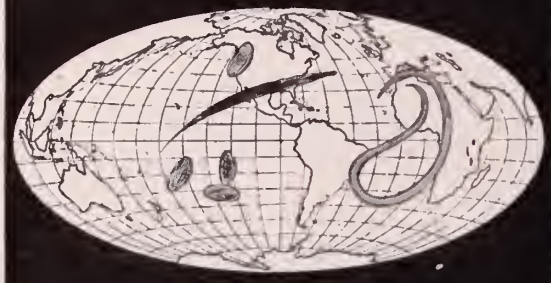
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Emory University School of Medicine, and at the Georgia College of Eclectic Medicine and Surgery in Atlanta, where he was graduated in 1911.

After engaging in the general practice of medicine in Hahira for 10 years, he came to Florida in 1921, locating in Winter Garden. He continued to practice there for 34 years. A past president of the staff of West Orange Memorial Hospital, he had been in charge of the West Orange Welfare Clinic in Winter Haven since 1942. He was also railway surgeon for the Seaboard Air Line and the Atlantic Coast Line railroads in that area. He was keenly interested in local athletic activities for the youth of the community and since 1947 had been president of the Winter Garden Recreational Association. A Mason, he was a member of the Briggs Shrine.

Dr. Lawson was a senior member of the Orange County Medical Society, having joined it only three years after its organiaztion in 1918. For more than 30 years he had been a member of the Florida Medical Association, and he also held membership in the American Medical Association.

Surviving are the widow, Mrs. Elizabeth Wilkes Lawson, and one daughter, Mrs. Albert Eugene Cowart, both of Winter Haven; two sons, Carlton W. Lawson, of Orlando, and Ben Hill Lawson Jr., of Jacksonville; four grandchildren, Michael and Matthew Lawson, of Jacksonville, and Ann Elizabeth Cowart and Eugene Cowart, of Winter Garden; one brother, Henry B. Lawson, of Macon, Ga., and one sister, Mrs. S. W. Webb, of Ocala.

1955 Medical District Meetings

October 10, District D, Fort Lauderdale
October 11, District C, Lakeland
October 12, District B, Gainesville
October 14, District A, Pensacola

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BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. George T. F. Rahilly of Fort Lauderdale announce the birth of a son, Richard Hamilton, in May, 1955.

Dr. and Mrs. Jerome H. Newman of Jacksonville announce the birth of a daughter, Elizabeth, on June 26, 1955.

Dr. and Mrs. Marvin V. McClow of Jacksonville announce the birth of a daughter, Mary Ellen, on July 2, 1955.

Dr. and Mrs. Joseph D. Katzman of Miami Beach announce the birth of a son, Kim Darryl, on June 12, 1955.

Dr. and Mrs. Maurice I. Edelman of Miami Beach announce the birth of a daughter, Susan Maureen, on June 24, 1955.

Dr. and Mrs. David Feigenbaum of Miami announce the birth of a son, Barry Allen, on July 7, 1955.

Marriages

Dr. Harry Jordan of Trenton and Miss Carolyn Haire were married July 1, 1955, in Ocala.

Dr. William G. Sutherland of Sarasota and Miss Norma Nancy Farrell were married July 9, 1955, in Sarasota.

Dr. Donald P. White Jr. of Jacksonville and Mrs. Sally Fitch Knight were married July 9, 1955, in St. Augustine.

Deaths — Other Doctors

Rosenthal, Julius M., Miami Beach July 10, 1955

Deaths — Members

Wilcox, Clarence Robert, Jacksonville August 2, 1955

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Bumbalo, T. S., Gustina, F. J., and Oleksiak, R. E.:
J. Pediat. 44:386, 1954.

White, R. H. R., and Standen, O. D.:
Brit. M. J. 2:755, 1953.

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Brown, H. W.:
J. Pediat. 45:419, 1954.

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Activities of Auxiliary, Like Hurricane, Blow In

Just as low pressure areas form hurricanes, the summer months are the planning months for the year's activity of the component auxiliaries and the Florida State Medical Auxiliary. These past summer months have been no exception.

With the cooperation and assistance of the President, Dr. John D. Milton, and the Managing Director, Ernest Gibson, along with the members and office staff of the Florida Medical Association, the Auxiliary has printed its first yearbook containing such information as the lists of officers and chairmen of the Woman's Auxiliary to the American Medical Association, the Woman's Auxiliary to the Southern Medical Association and the Woman's Auxiliary to the Florida Medical Association. A complete roster of members for 1954-55 has been included also as well as lists of the various component auxiliary chairmen of projects and programs and a short outline of the work of each of these. We are, indeed, appreciative of this cooperation and help and wish to acknowledge in this article our thanks for having such a fine medical association with which to work.

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1954 'Alflorone' | 1955 Deltra®

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There has long been a need for this yearbook but until this year, when the Association could help us through its office staff with the printing, we have never been able to afford one.

As our Auxiliary grows in number of component auxiliaries and in number of members, we are finding that we have greater needs in program material and in projects. These are being well met as they come up.

The summer months past, not being an exception, have again brought a whirlwind of activity to start the hurricane month — September.

Mrs. S. J. Beale, Jacksonville, hospitality chairman for the Florida Medical Auxiliary, has made arrangements for a fine meeting for the conference of component auxiliary presidents, presidents-elect and state chairmen. Mrs. S. S. Lombardo, state president, has planned an outstanding program for this conference at which Mrs. S. J. Wilson, state president-elect, will preside. Making one trip do for two purposes, the day following this conference the mid-year board meeting of the Florida Auxiliary is being held at which business will be transacted to bring the Auxiliary into line and up-to-date on what has transpired to this time.

The conference and board meeting are to be held September 28-29 at Ponte Vedra Inn, Ponte Vedra Beach, Fla.

Unlike the hurricane season, however, the Florida State Auxiliary activity continues throughout the year. October 10, 11, 12 and 14 will bring the district workshops which are held in conjunction with the medical district meetings of the Florida Medical Association. This year these meetings will be held as follows:

October 14, District A, Pensacola: Mrs. S. G. Kennedy, 2nd vice president, in charge of program and presiding.

October 12, District B, Daytona Beach: Mrs. John Bloom, 3rd vice president, in charge of program and presiding.

October 11, District C, Lakeland: Mrs. William Hodges Jr., 4th vice president, in charge of program and presiding.

October 10, District D, Fort Lauderdale: Mrs. E. W. Cullipher, 1st vice president, in charge of program and presiding.

Arrangements for these meetings are being made respectively by the Escambia County Auxiliary, the Volusia County Auxiliary, the Polk County Auxiliary and the Broward County Auxi-

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REFERENCE: 1. Robinson, R. C. V., *J.A.M.A.* **157**:1300, April 9, 1955.

liary. Further details will be included in the program for the meetings.

The workshop meetings, as all other meetings of the Auxiliary, are open to all doctor's wives, not just those who are members of the Auxiliary. These workshop meetings give a particularly good chance to doctor's wives to renew old acquaintances and to make new ones. It is the friendliness and the acquaintances that help to make the members of the Auxiliary active and happy members for the friendship we find for each other is the very thing to increase our activity and understanding.

We have planned to discuss in some detail the various projects of the Auxiliary in articles for The Journal during this year and to give some information about the activity on these projects at the national, state and local levels.

Starting our year with 23 component auxiliaries and many members-at-large, the hurricane of activity in planning that has taken place during the summer will be, we are sure, a good wind that will bear good will.

MRS. RICHARD F. STOVER

BOOKS RECEIVED

Ion Exchange and Adsorption Agents in Medicine: The Concept of Intestinal Bionomics. By Gustav J. Martin, Sc.D. Pp. 333. Price, $7.50. Boston, Little, Brown and Company, 1955.

For more than 10 years the author has been engaged in the investigation of ion exchange resins for medical use. This book is the product of these years of extensive research into both the basic chemistry and clinical applications of ion exchange and adsorption agents. Dr. Martin, who is research director of Philadelphia's National Drug Company, makes clear at the outset that prophylaxis, not therapeutics, must be the goal.

Two preliminary results of Dr. Martin's efforts were the application of the anion exchangers in the treatment of peptic ulcer and the use of cation exchangers for sodium reduction. As a result of the launching of these two resin types for general clinical use, a broader and more important sphere of application has arisen — the conditioning of the gastrointestinal tract, a state in which toxic chemicals are retained in the intestine and beneficial and nutrient materials permitted entrance into the system. This could well be defined as differential or selective ion exchange and adsorption for medical purposes.

"It is my contention, as yet unsubstantiated by clinical observations," writes Dr. Martin in the foreword, "that all chronic degenerative disease has as an important component in its etiology the absorption from the intestine of small quantities of toxic chemicals. These agents produce imperceptible but irreversible changes in tissues and in the course of years create gross pathology. I believe that the absorption of these toxic agents can be prevented by proper selection of ion exchange and adsorption materials. As a first effort in substantiation of my major theme, I offer the material of this volume."

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When Minds Go Wrong. By John Maurice Grimes, M.D. Pp. 246. Price $3.50. New York, The Devin-Adair Company, 1954.

This book was inspired by the author's shocking discoveries made in a nationwide study of the care of the mentally ill in state and private institutions. Dr. Grimes, a psychiatrist, recounts his investigations of 75 hospitals all over the country and his experiences while employed in a number of them. He then offers sound and proven methods for correcting the deplorable, and at times all but unbelievable, conditions he encountered: "He would take politics out of hospital appointments and eliminate the attendants altogether who virtually run the hospitals. Only doctors, psychiatrists, and registered nurses would be on hand. He would discontinue the asylum-type institutions and for them would substitute village-type rehabilitation centers which have been spectacularly successful in Europe. Dr. Grimes also recommends a complete change in the handling of patients, based on his years of experience, observation, and study. Only by intelligent and widespread changes can we successfully handle the alarming increase in the numbers of the mentally ill." This book is as constructive as it is shocking.

Handbook of Medical Treatment. Edited by Milton J. Chatton, A.B., M.D., Sheldon Margen, M.A., M.D., and Henry D. Brainerd, A.B., M.D. Pp. 380. Price, $3.00. Los Altos, Calif., Lange Medical Publications, 1954.

The continued acceptance of the first three editions of this handbook has stimulated the authors to undertake this fourth edition of this especially practical and useful collection of therapeutic procedures. For the present edition, they have sought the assistance of several new authors whose experience and competency in their various specialties they believed would enhance the value of the book. Accordingly, there has been a rather considerable revision of the text with a significant expansion in the size of the book. They are gratified that the new contributors have made a careful and refreshing presentation of the significant therapeutic advances of the past year. The book is designed to meet an important need of both medical student and practitioner for it serves as a guide, once diagnosis is established, to the most effective therapeutic measures at the earliest possible moment. As stated in the Foreword, it has become a constant bedside companion of the physician on the firing line of medical practice.

Make Inferiorities and Superiorities Work For You. By Samuel Kahn, M.D., Ph.D. Pp. 184. Ossining, N. Y., Dynamic Psychological Society Press, 1954.

This book is intended to be realistic, practical, and useful, and has for its purposes: (1) Prevention of some inferiority feelings; and (2) removing, understanding, or diminishing the inferiority complex from personality. Since this removal is not often accomplished, the chapters emphasize the methods by which one may handle, prevent or decrease feelings of inferiority. In addition, much of this volume is dedicated to mental hygiene — that is, how one may prevent the development of inferiorities and the inferiority complex in children and adults.

The campaign strategy for the defeat of inferiorities has three points of attack: (1) Understanding, (2) Prevention and (3) Treatment. The description, origin, and effects of inferiorities and their natures are discussed. The treatment, removal, insight, and avoidance of inferiorities in one's personality also are considered. Suggestions are offered on how to protect and guide children so that they may be able to avoid inferiorities, advice especially helpful to parents and teachers.

The author, who is Associate Professor of Psychiatry and Psychology at Long Island University, devotes 60 pages to brief biographies of famous people with inferiorities.

Meat...

and Biologic Facts of Protein Metabolism

The classical work of Cannon and his associates* in the field of protein metabolism has contributed significantly to our knowledge of the biologic utilization of protein. It has established that the dietary absence of a single amino acid quickly changes the direction of metabolic activity from anabolism to catabolism. Apparently all the nonessential amino acids play some part in sparing the essential amino acids, and all may be regarded as indispensable for optimal nutrition. It has been suggested "that for maximal tissue-utilization of amino acids at least twenty per cent of the total dietary nitrogen should come from other sources than essential amino acids."

In undernourished subjects the maintenance requirement for each essential amino acid is much greater—two to almost five times greater—than in healthy subjects.

Although an optimal caloric intake facilitates optimal utilization of amino acids, a reducing regimen need not curtail full utilization of these nutrients. It has been shown that a useful degree of amino acid utilization can be attained with caloric intake considerably below the optimal.

Minerals appear to be important in the process of amino acid metabolism. Evidence indicates that either phosphate or potassium deficiency might adversely influence amino acid utilization. Absence of either ion from experimental depletion rations leads to depression of appetite and slowing of the processes of protein repletion.

B complex vitamins also affect the metabolism of proteins and amino acids. For example, rats fed a high protein diet require a high intake of B complex vitamins in order to maintain normal growth rates. Omission from the ration of any one of these vitamins (riboflavin, thiamine, pyridoxine, or pantothenate) is accompanied, in varying degrees, by lower food consumption and slower weight gain.

Meat of all cuts and kinds is high in its content of protein, and provides well proportioned amounts of essential and nonessential amino acids. Meat also supplies valuable amounts of essential minerals, especially iron, phosphorus, potassium and magnesium, as well as important quantities of all components of the vitamin B complex, thus assuring maximal utilization of the amino acid components.

*Cannon, P. R.; Frazier, L. E., and Hughes, R. H.: Factors Influencing Amino Acid Utilization in Tissue Protein Synthesis, in Symposium on Protein Metabolism, New York, The National Vitamin Foundation, Inc., 1954, pp. 55-90.

The nutritional statements made in this advertisement have been reviewed and found consistent with current medical opinion by the Council on Foods and Nutrition of the American Medical Association.

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Pomp and Pestilence, Infectious Disease, Its Origins and Conquest. By Ronald Hare, M.D. Pp. 224. Price $5.75. New York, The Philosophical Library, Inc., 1955.

This book abounds in intriguing episodes from the history of medicine, coming down across the centuries to the attack of modern science upon epidemics, with the development of mass inoculation, sanitary reform, and the isolation hospital. The subject is one of universal interest and ranges here from a description, for example, of the smallpox epidemic which, carried to Mexico by Cortes, did far more than the Conquistador to destroy the Aztec empire, to wholly fascinating accounts of bacteriologic detail about the families that inhabit the throats of us all. The seven chapters are entitled: Parasites and Parasitism; Man and His Parasites; Parasites and Pestilence; Miasmas or Microbes; The Reaction of the Community; The Reaction of the Individual; and Parasites and Populations. The author is Professor of Bacteriology at St. Thomas' Hospital in the University of London.

Management of Addictions. Edited by Edward Podolsky, M.D. Pp. 413. Price, $7.50. New York, Philosophical Library, 1955.

Today more than ever before the causes of addiction and therapeutic measures to control addiction are a problem to which the medical profession is giving serious thought and attention. This volume, therefore, is of particular interest in that it presents a discussion of addictions to alcohol and various drugs by leading authorities in the field. The mechanisms of addiction are explored thoroughly and methods of therapy are presented in detail. The book is intended primarily for physicians, but it will prove of interest also to psychologists, sociologists, and others interested in the problem of addiction.

The Care of Your Skin. By Herbert Lawrence, M.D. Pp. 95. Price, $2.50. Boston, Little, Brown & Company, 1955.

Acne, the complexion problem of young adults, affects the personality development as well as the physical appearance of many a young man and young woman. The need for an authoritative account of the facts surrounding this commonest of all skin disturbances is a great and long-standing one, which this book meets. Here the cause of acne and its treatment are explained in a simple and helpful manner. In easy-to-read, conversational style, Dr. Lawrence, a San Francisco dermatologist and medical author, presents the major discoveries of recent years and the methods of treatment endorsed by the greatest dermatologists in the United States and abroad. He makes clear that many of the "miracle remedies" can do more harm than good, that acne is rarely helped and often aggravated by creams, pills, lotions, tonics, special soaps and other "sure cures," that successful treatment consists of a combination of processes, and that a cure cannot be effected overnight.

The basic object, Dr. Lawrence explains, is to remove excess oil from the skin. He tells how to accomplish this and gives complete information on proper cleansing, correct diet and exercise. In addition, he describes the specific beneficial treatments provided by dermatologists.

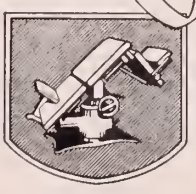
This book is a completely revised and rewritten version of his The Skin Problems Facing Young Men and Women, which, printed in limited edition, in 1948, received unusual notice and support from the medical profession. It should prove an invaluable aid to busy practitioners and specialists, and in the hands of parents and patients should be a common sense guide to daily treatment to supplement that given by the dermatologist. It is available to the medical profession at bookseller discounts on quantity orders.

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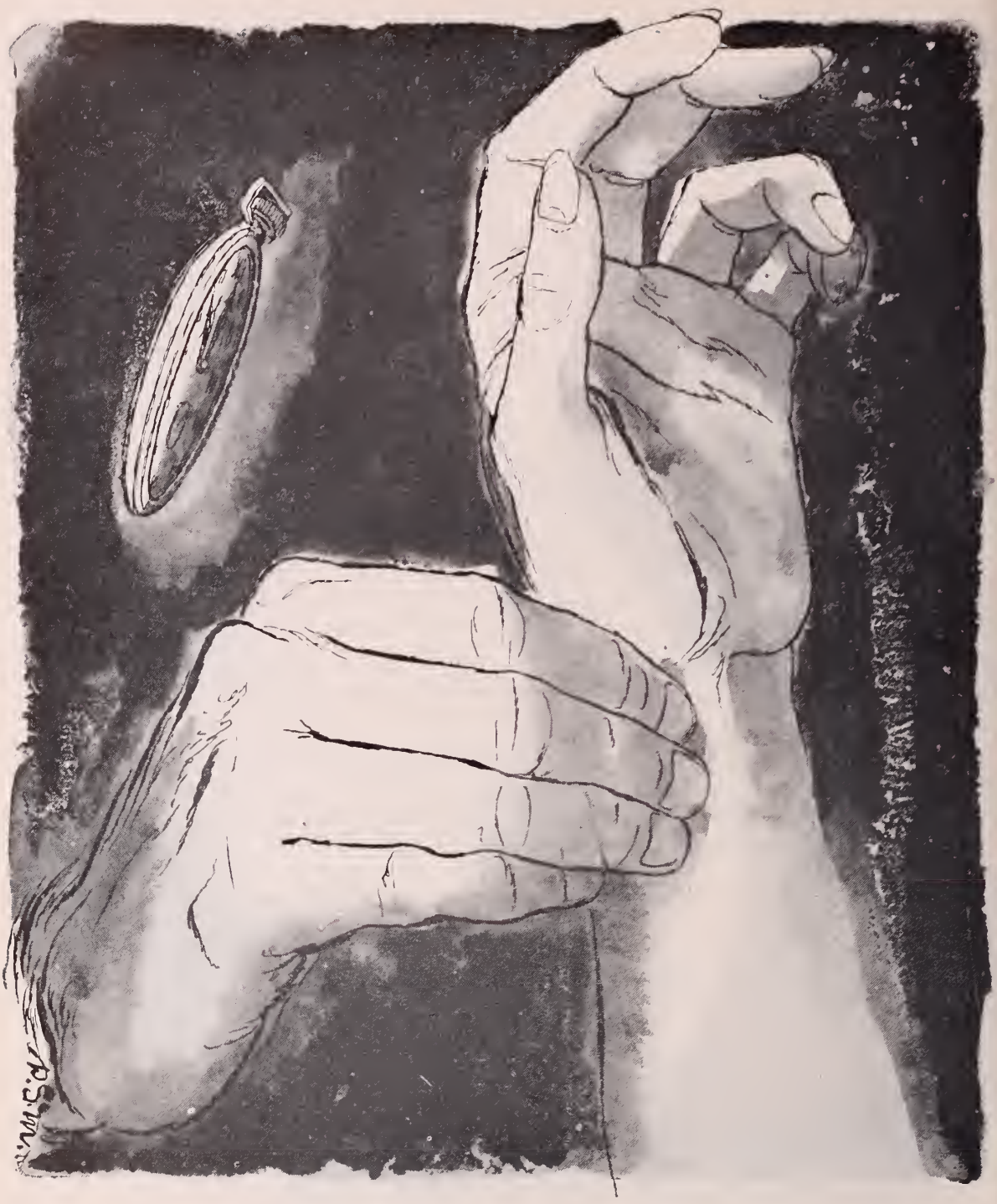
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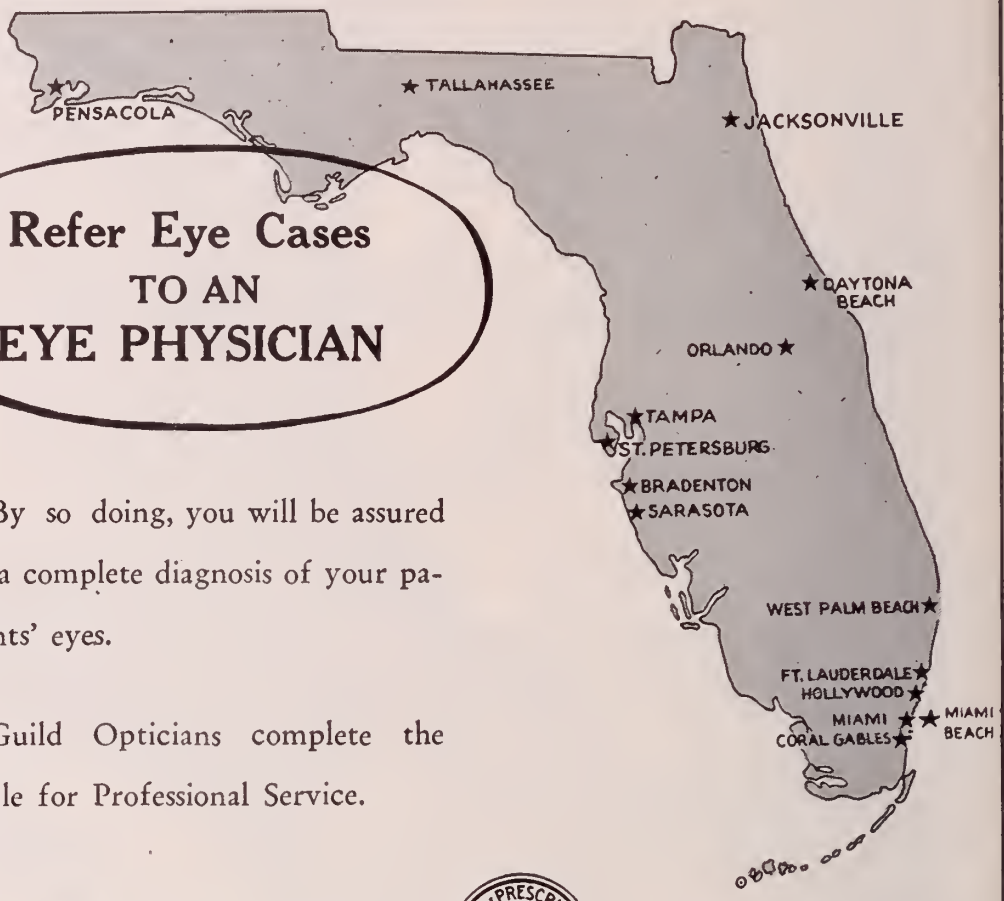
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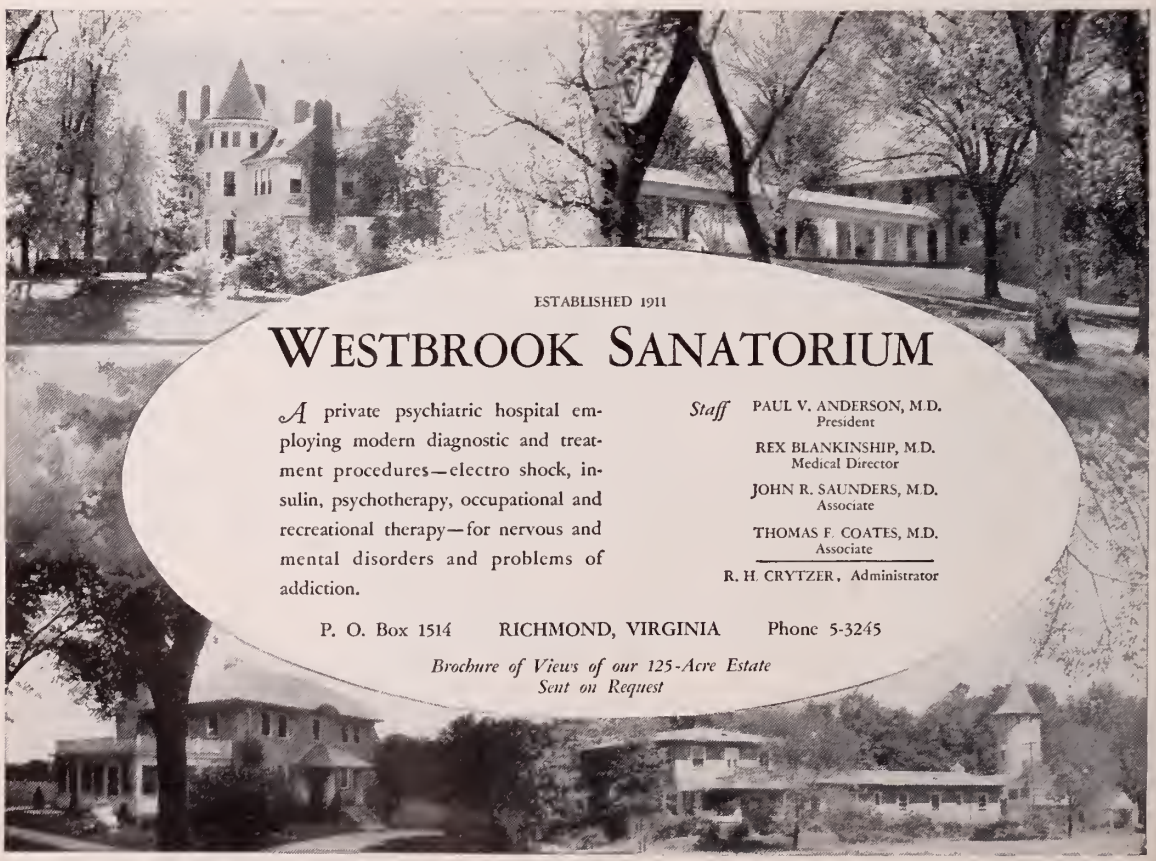
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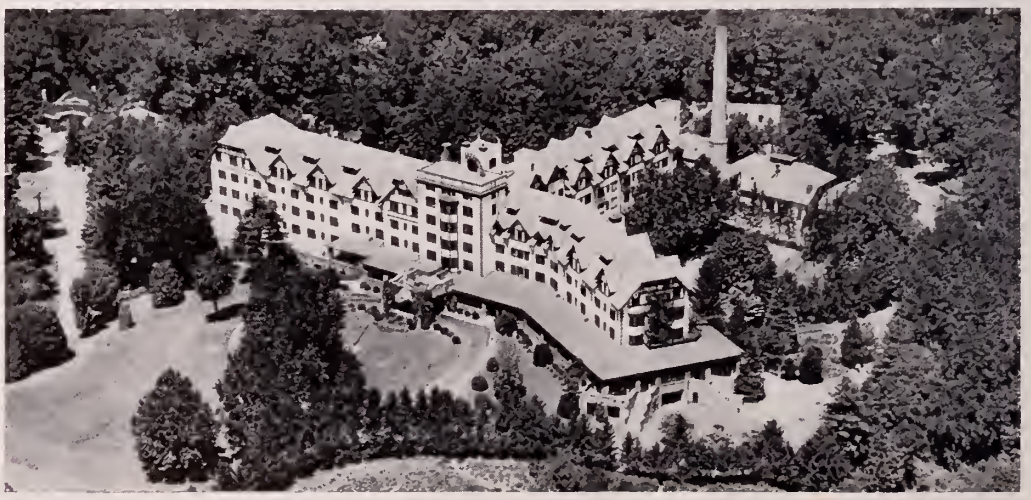
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Anesthesiologists, Soc. of	Wayland T. Coppedge Jr., Jax	William H. Houston, Jacksonville	" " " "
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Radiological Society	Hugh G. Reaves, Sarasota	Donald H. Gahagen, Ft. Lauderdale	" " " "
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Heart Association	Victor H. Kugel, Miami Beach	Edwin P. Preston, Miami	
Hospital Association	Mr. Pat N. Groner, Pensacola	Mr. Steve F. McCrimmon, C. Gbls.	St. Petersburg, Dec. 8-9, '55
Medical Examining Board	Morris B. Seltzer, Daytona Bch.	Homer L. Pearson Jr., Miami	Miami Beach, Nov. 20-22, '55
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Woman's Auxiliary	Mrs. Samuel Lombardo, J'sonville	Mrs. Leffie M. Carlton Jr., Tampa	Miami Beach, May 13-16, '56
American Medical Association	Elmer Hess, Erie, Pa.	Geo. F. Lull, Chicago	Chicago, June 11-15, '56
A.M.A. Clinical Session	Elmer Hess, Erie, Pa.	Geo. F. Lull, Chicago	Boston, Nov. 29-Dec. 2, '55
Southern Medical Association	Robt. L. Sanders, Memphis, Tenn.	Mr. V. O. Foster, Birmingham	Houston, Nov. 14-17, '55
Alabama Medical Association	F. L. Chenault, Decatur	Douglas L. Cannon, Montgomery	Birmingham, Apr. 19-21, '56
Georgia, Medical Assn. of	H. Dawson Allen Jr., Milledgeville	David Henry Poer, Atlanta	Atlanta, May 13-16, '56
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Southeastern Allergy Assn.	Ben Miller, Columbia, S. C.	Kath. B. MacInnis, Columbia, S.C.	Charlotte, N. C., Oct. '56
Southeastern, Am. Urological Assn.	Sidney Smith, Raleigh, N. C.	Robert F. Sharp, New Orleans	Hollywood, Mar. 25-29, '56
Southeastern Surgical Congress	Donald S. Daniel, Richmond	B. T. Beasley, Atlanta	Richmond, Mar. 12-15, '56
Gulf Coast Clinical Society	Walter C. Payne Sr., Pensacola	Barkley Beidleman, Pensacola	Pensacola, Oct. 27-28, '55

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County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Total Members
Alachua	Edwin H. Andrews, Gainesville	Henry S. Blank, Gainesville	2nd Tues.	56
**Bradford, Gilchrist, Union*				
Bay	William F. Humphreys Jr., Panama City	Roderick C. Webb, Panama City	1st Tues.	28
Brevard	Lee Rogers Jr., Cocoa	Charles E. Russell, Cocoa	2nd Tues.	37
Broward	Ernest E. Serrano, Hollywood	Alfred E. Cronkite, Fort Lauderdale	4th Tues.	121
Columbia	Robert B. Harkness, Lake City	Thomas H. Bates, Lake City	1st Mon.	11
**Baker*				
Dade	L. Washington Dowlen, Miami	Robert F. Dickey, Miami	1st Tues	722
DeSoto-Hardee-Highlands-Glades	Gordon H. McSwain, Arcadia	Harold S. Agnew, Arcadia	1st Tues.	28
Duval	Raymond H. King, Jacksonville	Eugene M. Frame, Jacksonville	1st Tues.	300
**Clay*				
Escambia	George W. Morse, Pensacola	Paul F. Baranco, Pensacola	2nd Tues.	107
**Santa Rosa*				
Franklin-Gulf	Warren T. Weathington, Apalachicola	Joseph P. Hendrix, Port St. Joe	Last Wed.	6
Hillsborough	Frank S. Adamo, Tampa	Julien C. Pate Jr., Tampa	1st Tues.	190
Indian River	Kip G. Kelso, Vero Beach	Vernon L. Fromang, Vero Beach	2nd Tues.	9
Jackson-Calhoun	Henry I. Langston, Marianna	Francis M. Watson, Marianna	Quarterly	17
Lake	Louis R. Bowen, Eustis	J. Basil Hall, Tavares	1st Wed.	29
**Sumter*				
Lee-Charlotte-Collier-Hendry	Baker Whisnant, Fort Myers	James L. Bradley, Fort Myers	3rd Mon.	38
Leon-Gadsden-Liberty-Wakulla-Jefferson	William L. Hunter, Monticello	Odis G. Kendrick Jr., Tallahassee	Quarterly	66
Madison	A. Franklin Harrison, Madison	Wallace E. Winter, Madison		6
Manatee	Marjorie L. Warner, Bradenton	Harvey C. Pauley Jr., Bradenton	2nd Tues.	31
Marion	William H. Turnley, Ocala	Bertrand F. Drake, Dunnellon	3rd Tues.	30
**Levy*				
Monroe	Ralph Herz, Key West	William R. Ploss, Key West	1st Thurs.	14
Nassau	David G. Humphreys, Fernandina Beach	John W. McClane, Fernandina Beach	Last Fri.	11
Orange	Don C. Robertson, Orlando	Walter A. Derrick, Orlando	3rd Wed.	192
**Osceola*				
Palm Beach	Edwin W. Brown, West Palm Beach	James R. Anderson, West Palm Beach	4th Mon.	143
Pasco-Hernando-Citrus	Harry G. Brownlee, Zephyrhills	W. Wardlaw Jones, Dade City	2nd Thurs	16
Pinellas	Clyde O. Anderson, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	227
Polk	Samuel J. Clark, Lakeland	Marion W. Hester, Lakeland	2nd Wed.	101
Putnam	Grover C. Collins, Palatka	Alfred P. Peretti, Palatka	2nd Tues.	10
St. Johns	George C. Hopkins, St. Augustine	Reuben J. Plant Jr., St. Augustine	3rd Tues.	21
St. Lucie-Okeechobee-Martin	Henry E. Branca, Fort Pierce	Adrian M. Sample, Fort Pierce	3rd Thurs	24
Sarasota	Melvin M. Simmons, Sarasota	Andrew J. Jesacher, Sarasota	2nd Tues.	58
Seminole	John M. Morgan, Sanford	Terry Bird, Sanford	2nd Tues.	20
Suwannee	William P. Blackmon, Jasper	Hiram B. Curry, Jasper	1st Sat.	10
**Hamilton, Lafayette*				
Taylor	John H. Parker Jr., Perry	Ralph J. Greene, Perry	Last Fri	5
**Dixie*				
Volusia	Robert L. Miller, Daytona Beach	Achille A. Monaco, Daytona Beach	2nd Tues.	84
**Flagler*				
Walton-Okaloosa	Richard H. Lee, Crestview	Frederic E. Caldwell, Fort Walton Beach	3rd Tues	20
Washington-Holmes	L. H. Paul, Bonifay	Baylye W. Dalton, Chipley		5
				Total 2,793

**Supervise and aid until organized separately.*

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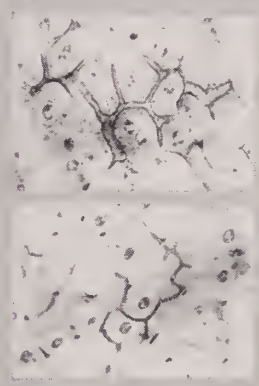
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(1) Clara, M.: Med. Monatsschr. 7:356, 1953. (2) Brauer, R. W., and Pessotti, R. L.: Science *115*:142, 1952. (3) Schwimmer, D.; Boyd, L. J., and Rubin, S. H.: Bull. New York M. Coll. *16*:102, 1953.

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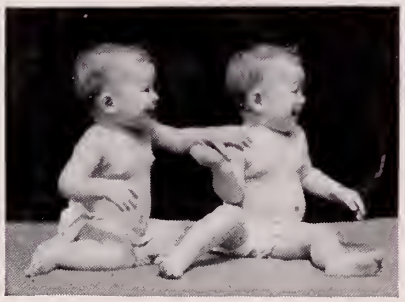


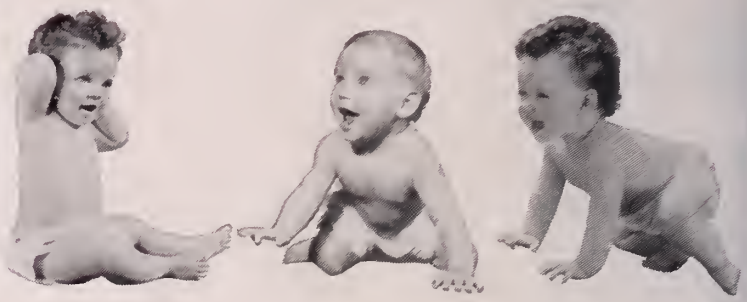
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(1) Jeans, P. C., in A. M. A. Handbook of Nutrition, ed. 2, Philadelphia, Blakiston, 1951, pp. 275-278.

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The Journal OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XLII OCTOBER, 1955 No. 4

MEDICAL DISTRICT MEETINGS
OCTOBER 10-14, 1955

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Bernard J. McCloskey

Acute Renal Failure
Oscar W. Freeman Jr., Meredith Mallory, Fred Mathers, W. Dean Steward

Treatment of Varicose Veins by Stripping
James R. Anderson

Physicians and Medicine in Early Alachua County
Part II—War and Pestilence

Program, Medical District Meetings

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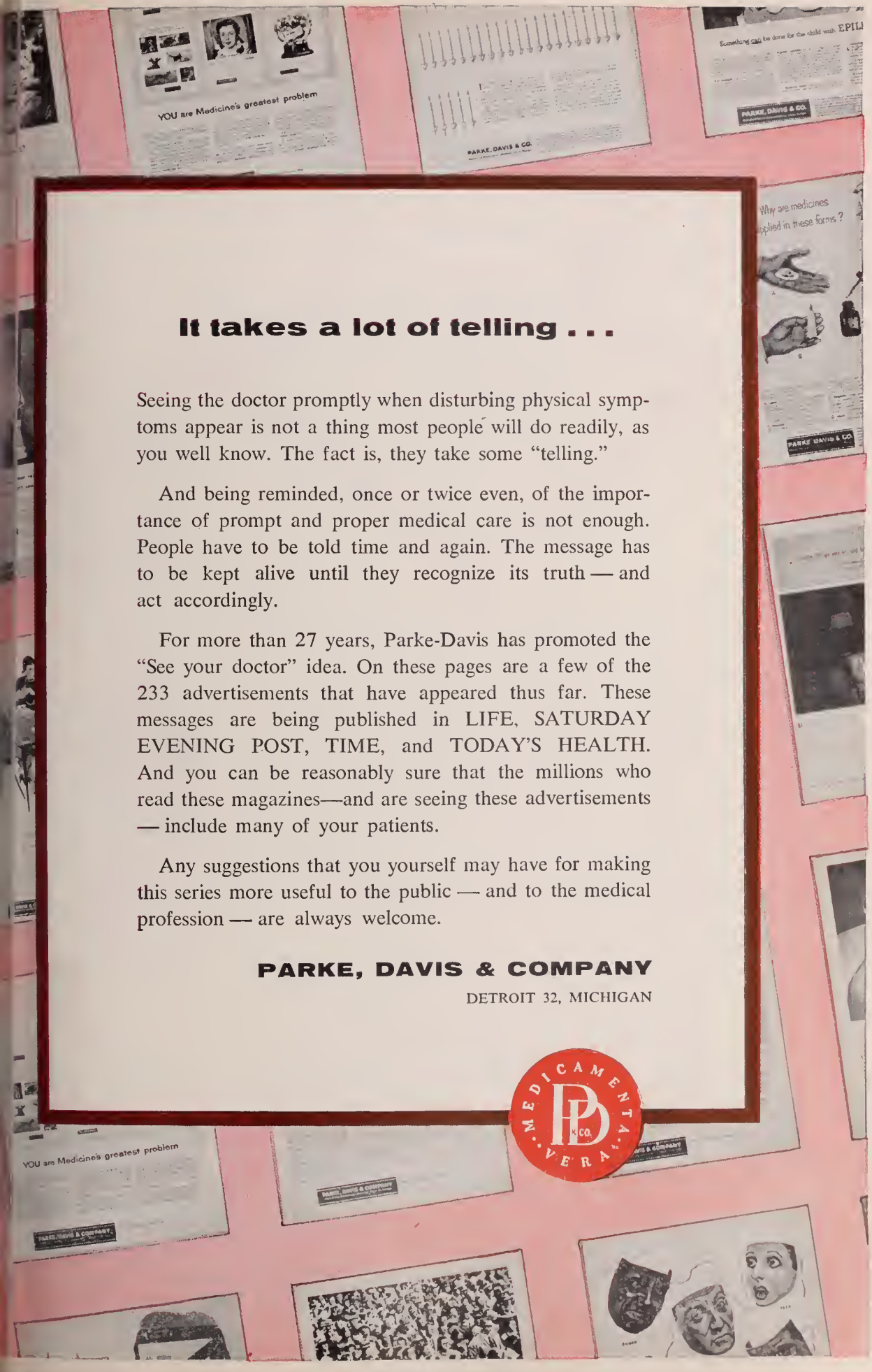
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VOLUME XLII, No. 4 • *October, 1955*

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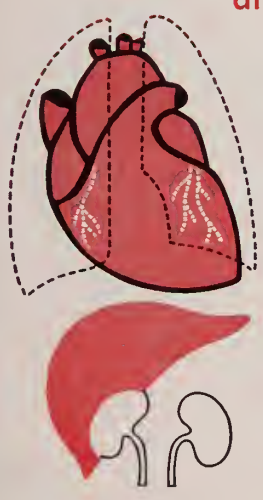
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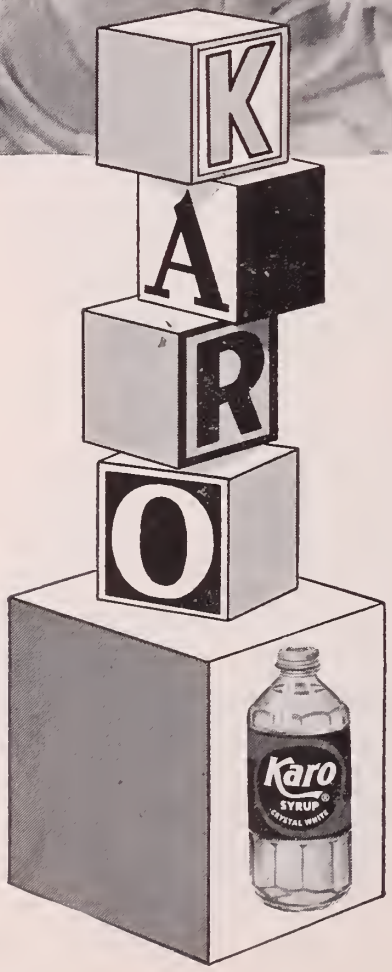
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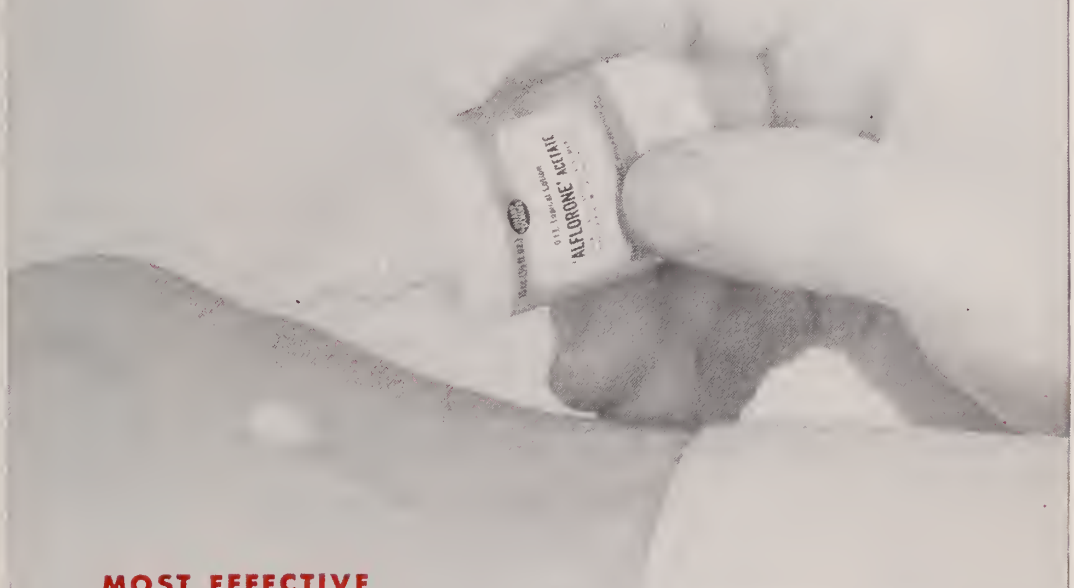
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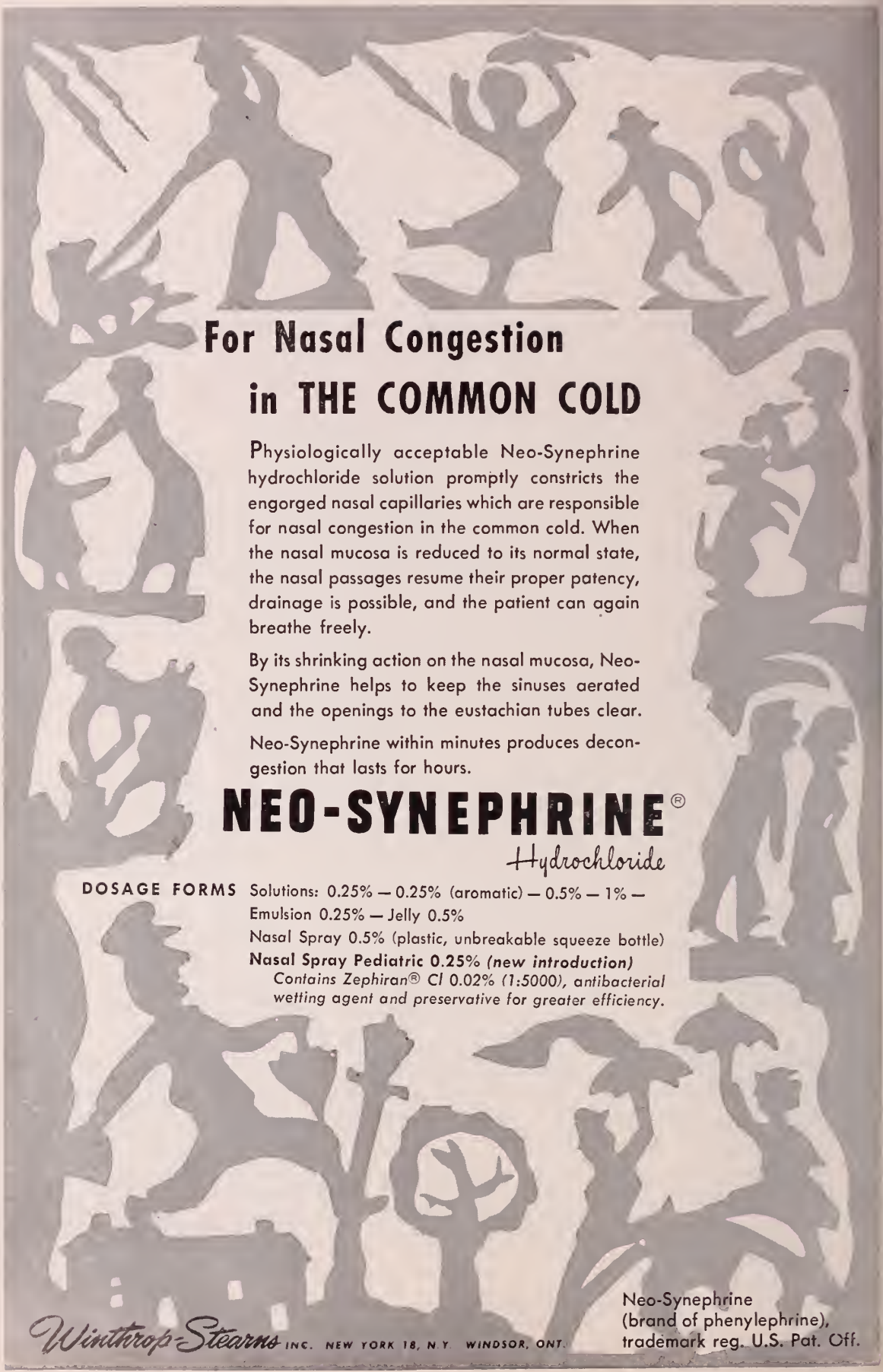
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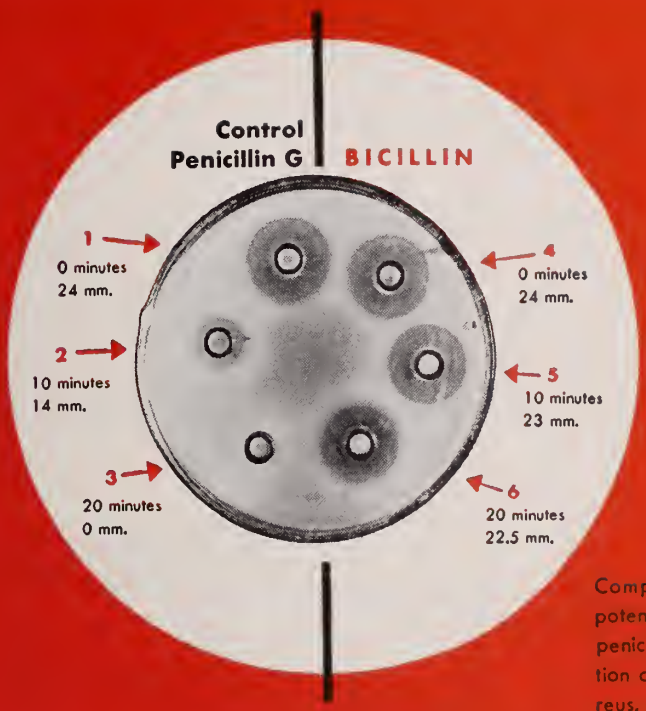
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1. American Medical Association: New and Nonofficial Remedies. J. B. Lippincott Co., Philadelphia, 1954, p. 147.

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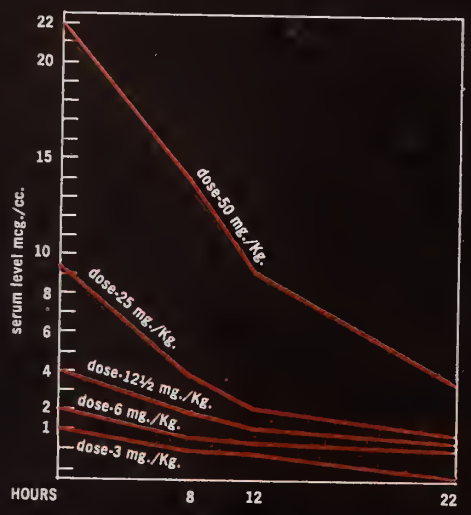
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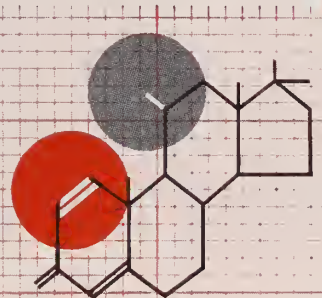
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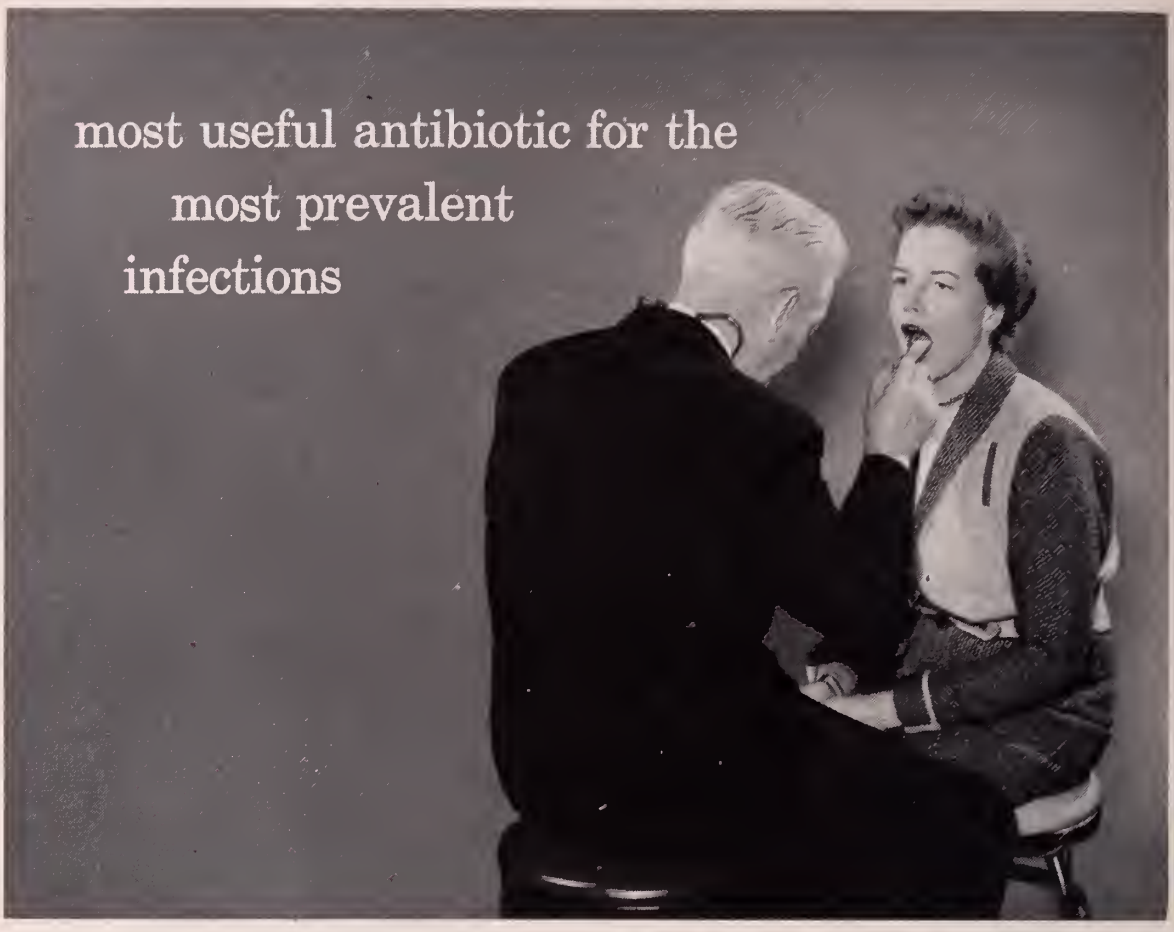
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Systemic Blastomycosis: Report of a Case

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AND
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TAMPA

Recently, we had the opportunity to observe a patient with pulmonary and cutaneous manifestations of North American blastomycosis, and to witness the response to therapy with stilbamidine. Prior to the introduction of stilbamidine in 1951, Martin and Smith[1] reported that 92 per cent of the patients with the generalized form of the disease died within two years, although the prognosis was relatively good if involvement was limited to the skin. The disease is encountered most frequently in the Chicago area and in Louisiana, Tennessee and North Carolina, but there has been an increase in the number of cases reported in other areas.[2-4] All physicians are aware that recognition of any disease increases proportionally with the rise in suspicion on the part of the doctor. This case is reported, therefore, as another reminder of a disease, rare in this area, which may cause cutaneous and/or visceral lesions.

Blastomycosis may be so slowly progressive that the physician is not impressed with its severity, or it may run a rapidly fatal course. The disease may begin with cutaneous, pulmonary, osteomyelitic or even genitourinary symptoms, and consequently should be of interest to practitioners in all branches of clinical medicine. Unfortunately, there is no accurate record of the incidence of this disease in Florida because reporting it is not required by the State Board of Health.

Before 1951 treatment of blastomycosis included a wide variety of measures.[5] Some were of value: (1) The antibiotics were mostly useful in controlling secondary bacterial infections. (2) Potassium iodide usually proved effective to some degree, but was not given immediately when the patient was hypersensitive to the organism as determined by skin test.[2] In such a case, the hypersensitivity was decreased artificially by administering gradually increasing doses of vaccine. (3) Surgery consisting of drainage of deep lesions was often desirable,[2] and, if the lesions were accessible and single, they were excised. (4) Roentgen therapy was useful in cutaneous lesions, particularly if combined with iodides and vaccines. Schoenbach, Miller, Ginsberg and Long[6] were the first group of investigators to use stilbamidine in the treatment of blastomycosis and described their results in 1951. Since then, there has been a reduction in the mortality rate in systemic blastomycosis.

Pharmacology of Stilbamidine

The standardization of the size of the dose, method of administration, and duration of treatment had been established for stilbamidine prior to its use in blastomycosis. An excellent review of the properties of the drug was published by Schoenbach and Greenspan[7] in 1948, and summarized by Smith[8] in 1953. The following data were obtained from the latter source.

The drug possesses several unique properties and, if used injudiciously, can cause either immediate or delayed complications. Stilbamidine deteriorates rapidly when exposed to light, and a 15 minute exposure to direct sunlight may reduce its therapeutic efficiency and at the same time produce a toxic by-product capable of fatal renal and hepatic damage. Another unusual property of stilbamidine, upon exposure to ultraviolet light, is the development of fluorescence which can be useful in chemical determinations. Stilbamidine promptly leaves the blood stream and is stored in the body, being excreted slowly over several weeks or months. Patients, therefore, should be protected not only during treatment, by covering infusion bottles with dark paper or towels, but also after treatment by avoiding exposure to direct sunlight for one to two months. Recently, 2-hy-

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droxystilbamidine has been introduced, which is much less affected by sunlight and is equally as effective as stilbamidine.[9] The drug is administered intravenously, usually in doses of 150 mg. dissolved in 500 ml. of 5 per cent glucose. Daily doses are given until a total dose of 3.5 to 4.6 Gm. is reached. Some advocate three courses of 10 days each, separated by rest periods of one to two weeks.

If the drug is administered too rapidly, circulatory collapse may occur, but usually no discomfort is noted if it is given slowly or diluted properly. A tendency toward development of thrombophlebitis has been recorded by some observers.[5] Late toxic manifestations are less easily controlled and consist of a neuropathy, curiously enough, involving the sensory division of the trigeminal nerve. The onset of this complication is delayed several months after cessation of treatment. There is no known treatment for this late sequela, and it usually disappears spontaneously after several months. It is believed to be related to exposure to sunlight since the incidence is lower in protected patients. Smith[8] reported another late complication, namely, the development of hepatic and renal damage several months after completion of therapy, but he pointed out that this has been avoided since the deleterious effect of sunlight was discovered.

Report of Case

The patient, a 56 year old white man, was admitted to Tampa Municipal Hospital on April 20, 1954. One year previously, he had noted the simultaneous onset of exertional dyspnea, a mild nonproductive cough, and a small wartlike growth on the right cheek. Prior to that time his health had been excellent. He was a native of West Virginia, and although he had lived in Indiana near Chicago for 18 years of his life, he had resided in Florida for the past 14 years.

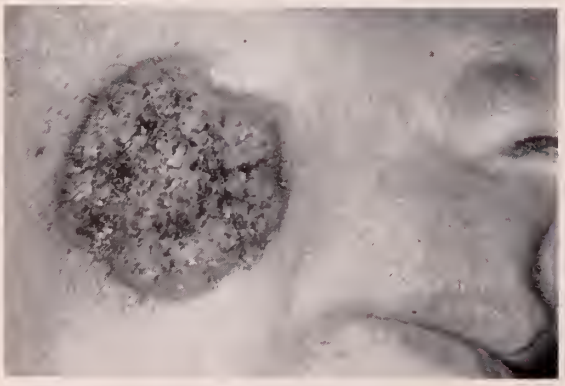


Fig. 1.— Photograph of a cutaneous lesion of the right cheek in a patient with systemic blastomycosis.

During the year before admission to the hospital in 1954, he consulted several doctors and was treated for the most part as a cardiac patient because of the respiratory distress. Meanwhile, the facial lesion became enlarged and ulcerated. He was subsequently seen by one of us (W.W.W.), whose biopsy specimen of the right cheek showed double-contoured bodies compatible with blastomycosis. The lesion was a rounded, irregular, verrucous-edged, elevated crusting ulcer almost vermilion in color (fig. 1). Upon admission to the hospital, the patient was not in acute distress, but appeared chronically ill and slightly dyspneic. The remainder of the physical examination gave normal results, especially that of the cardiovascular system. No rales were heard over either lung field.



Fig. 2.— Roentgenogram of the chest of a patient with systemic blastomycosis prior to treatment.

Roentgen examination of the chest revealed a diffuse, bilateral, granular and nodular infiltration (fig. 2). Smears made from the skin lesions and sputum demonstrated Blastomyces dermatitidis, and this finding was confirmed by mycologic culture. Blood chemistry studies indicated hepatic and renal impairment as evidenced by abnormal retention of Bromsulphalein, elevation of thymol turbidity and increased blood urea nitrogen. During the first few days of observation, prior to starting treatment, a small lesion appeared on the right wrist at a site where the patient had inadvertently rubbed the skin lesion on the face.

Despite the abnormality in hepatic and renal function studies, we decided to treat the patient with stilbamidine because of the high mortality rate associated with systemic blastomycosis. In view of the known hepatotoxic effect of the drug, the initial dose was 10 mg. the first day, 25 mg. the second day, and a stepwise increase was continued until 150 mg. per day was reached. He was treated for 30 days and received a total of 4.2 Gm. By the twelfth day of treatment the lesion on the right wrist had completely disappeared, and there was diminution in the size of the facial lesion.

Since the patient was to receive daily fluids, we elected to insert an indwelling intravenous polyethylene catheter. After five days, however, we were forced to remove it because of the development of thrombophle-

bitis. Whether this condition was due to the drug or to the plastic tube is not known, but it proved to be mild and responded to conservative measures. No further complications during therapy were observed.

The patient improved slowly but progressively. There was a steady decline of the blood urea nitrogen level to normal. Curiously, there was a transient rise of the serum globulin during treatment. Improvement of the pulmonary lesions was slow, and definite roentgen evidence did not appear until completion of therapy (fig 3).



Fig. 3.— Roentgenogram of the chest of a patient with systemic blastomycosis at termination of treatment with stilbamidine.

There was, however, almost complete clearing of the skin lesion at the time of discharge from the hospital (fig. 4).

It is now nine months since completion of therapy, and the patient feels well except for diminution of light touch over the sensory portion of the trigeminal nerve on one side. This appeared as early as the third month after therapy was completed, but the condition has improved.

The patient received no therapy other than stilbamidine. Local roentgen therapy, potassium iodide, and vaccine therapy were purposely withheld to evaluate stilbamidine.

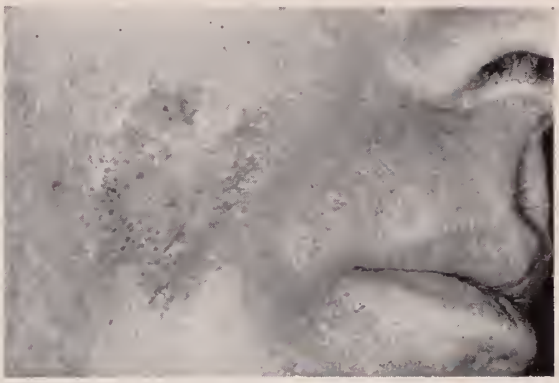


Fig. 4.— Photograph of a cutaneous lesion of the right cheek in a patient with systemic blastomycosis after termination of treatment with stilbamidine.

Conclusion

A case of systemic blastomycosis with excellent response to stilbamidine therapy is reported to illustrate the effectiveness of a new therapeutic agent in a highly fatal disease. Blastomycosis is a disease uncommon to this area, but important because its protean manifestations may make diagnosis difficult, and thereby delay the start of effective treatment.

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Hematuria During Treatment of Severe Hypertension with Hexamethonium Bromide and Pentolinium Tartrate

BERNARD J. MCCLOSKEY, M.D.
JACKSONVILLE

Hematuria of varying degrees of severity is a common occurrence in patients with hypertension, regardless of etiology, and the recent development of potent remedies for this condition has made it necessary to watch for undesirable side effects. Gross hematuria occurred in one of my patients during treatment with hexamethonium bromide and pentolinium tartrate.

Report of Case

A white man, aged 37, first consulted me in February 1951, complaining of hypertension. There was a history of acute pyelonephritis of the right kidney in 1939, which followed complete obstruction of the ureter by a stone. The stone was removed, the obstruction was relieved, and the pus yielded Bacillus coli and Bacillus pyocyaneus. In October, 1949, he had chronic pyelonephritis. The urine showed 2 plus albumin, many leukocytes and some erythrocytes; a proteus organism was isolated from culture. Treatment for one week with streptomycin caused the urine culture to become negative. He was treated for a year in a Naval hospital with bed rest, sedation, a low salt diet and then a strict rice diet. The blood pressure dropped from 190/140 to a low of 150/90, but the improvement was temporary. At that time the kidney function tests showed 45 per cent elimination of phenolsulfonphthalein in two hours and a urine dilution and concentration range from 1.010 to 1.022; the blood nonprotein nitrogen was 31.2 mg. per hundred cubic centimeters of blood. The funduscopic examination showed arterial spasm. The heart was normal in size, and an electrocardiogram gave negative evidence.

When I first examined the patient on Feb. 26, 1951, his only complaint referable to hypertension was recurrent headache. At that time the blood pressure was 190/140. The eyegrounds showed spastic arterioles, but no exudate or edema. The urea clearance was 85 per cent; the urine contained 2 plus albumin, but leukocytes and erythrocytes were absent.

From then until November 1952 he was treated with simple hypotensive drugs and sedatives. He abstained from meat, coffee, tobacco and alcohol without reduction of blood pressure.

On Nov. 27, 1953, he submitted to right unilateral surgical sympathectomy. This included resection of the ganglia from the fifth thoracic to the third lumbar, inclusive; removal of the right greater and lesser splanchnic nerves and a portion of the right semilunar ganglion. At this operation, the right kidney was inspected; the pelvis showed no deformity and the adrenal gland was free of tumor. On Feb. 19, 1954, he submitted to left hemisympathectomy, which included the left sympathetic chain from the fourth thoracic to the first lumbar ganglion, inclusive, the greater and lesser splanchnic nerves and the entire left semilunar ganglion. One month after the second sympathectomy, the casual sitting blood pressure was 160/120. On May 2, the pressure was 200/140, and at this time there was recurrence of occipital headache.

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On May 21, about three months after the sympathectomy, I began to give him trial doses of hexamethonium bromide subcutaneously. There was little effect on sitting blood pressure until 15 mg. of the ion was given. This dose reduced the pressure from 210/140 to 160/110. A dose of 25 mg. produced a fall to 130 100. Thirty milligrams caused the sitting pressure to fall to 110/90 in six minutes. This change caused dizziness of such degree that the patient insisted on lying down. After five minutes in the recumbent position, the pressure was 190/140. These wide variations persisted for 90 minutes, and finally the pressure was fixed at 160/110 in the standing position. After 120 minutes, he walked to his car without complaints. An electrocardiogram, made after the sudden drop to 110/90, did not show S-T depressions or other evidence of coronary insufficiency.

On June 1, it was decided to have the patient's wife give him two injections of 25 mg. of the ion each day. He was not able to tolerate the morning dose because of dizziness in the upright position. He took one dose at 4:30 p.m. each day for 26 days, and then had gross hematuria while working as a clerk. After the first day of bleeding, he continued the medicine for two days and had hematuria each day. He eliminated the drug for two nights with immediate cessation of the hemorrhage. He took another dose, which was followed next day by bleeding. When the drug was finally discontinued, the hemorrhage stopped immediately without treatment. Cystoscopic examination and retrograde pyelograms failed to show any explanation for the bleeding. There was no reduction of the sitting blood pressure in my office at any time during this treatment.

On Feb. 23, 1955, he began to take pentolinium tartrate by mouth. The dosage varied from 60 to 120 mg. per day. The total quantity taken was 860 mg. On the twelfth day of treatment, he voided bloody urine in my office after his day's work as a clerk. The bleeding stopped without treatment within 24 hours. Before the drug was started, the afternoon urine showed 3 plus albumin, many casts, occasional leukocytes, but no erythrocytes. The phenolsulfonphthalein excretion was 68 per cent in two hours.

Comment

I want to emphasize the history of acute right unilateral pyelonephritis in this patient in 1939 at the age of 25 years. If this infection had been eradicated completely, he might never have had hypertension. In 1949 he had a blood pressure of 190/140, associated with chronic pyelonephritis. The diagnosis on these occasions was easy; but there are times when it is most difficult, such as when the urine presents no abnormalities except for the presence of the infecting organism on culture. Arteriolar nephrosclerosis[1] may result from pyelonephritis; but when this stage has been reached, the mechanism of its production alters neither therapy nor prognosis. Pathologic changes

in the kidney after long-standing pyelonephritis produce changes in the glomeruli and arterioles which would probably result in increased fragility of capillaries.

The action of both hexamethonium bromide and pentolinium tartrate is to block both sympathetic and parasympathetic nerve impulses at the autonomic ganglia. The hypotensive effects, according to Fries and his associates,[2] are accompanied by decrease in cardiac output and decrease of pressure in the right side of the heart. They suggested that these alterations are due to venous pooling and blockade of reflex vasoconstriction. They noted no change in peripheral vascular resistance of any significance.

The more frequent undesirable side effects of the drugs are orthostatic hypotension, constipation, paralytic ileus, hypotonicity of the urinary bladder, impotence in the male and intolerance of cold.[3] I will add gross hematuria to the list. Postural hypotension represents the most frequent and most troublesome effect and may prevent adequate dosage for good recumbent effect.

The hemodynamics dealing with the body as a whole and the kidney in particular are complicated and controversial. This patient's surgical sympathectomy had no lasting beneficial effect on blood pressure. This result is in keeping with the opinion of deTakats[4] that hypertensive patients with irreversible renal damage do not respond favorably to operation. The failure of operation is explained in various ways: It might be due to bridging of nerve gaps, or it might be caused by the assumption of functions of small nests of sympathetic ganglion cells in the anterior spinal nerve roots. It is also clear that sympathectomy in some manner often produces an increase in non-neurogenic or intrinsic vascular resistance.[5] The only fact that I have to explain the hemorrhage is the sudden broad variations in blood pressure that occurred after hexamethonium injection when the patient changed from the sitting to the lying position, and vice versa. It would appear that the changes in vascular dynamics are greater than the ability of a damaged kidney to adjust in patients whose autonomic ganglia are blocked with hexamethonium.

Several observers[2] studied renal alterations following administration of hexamethonium and concluded they are similar to those observed with hypotensive agents of all types and probably are secondary to sudden variations of arterial pressure, rather than to any specific action of individual drugs. Renal plasma flow decreased sharply at the onset of the hypotensive response, regardless of the drug used. This evidence of vasoconstriction after blockade suggests that other pressor mechanisms are operating. Among these might be acute renal ischemia, mediated through renin and its effector substance, hypertensin; and the more slowly acting pressor substance, pherentasin, which is the only pressor substance consistently found in hypertensive blood and not in normal blood.[8] It suggests also that the autonomy of renal vessels, as first observed by Smith and his associates,[6] might be the controlling mechanism.

The bleeding effect of hexamethonium is not limited to the kidneys. Mandelbaum, Brook and Mandelbaum[7] reported a case in which the patient had a massive hemorrhage from a quiescent duodenal ulcer without previous sympathectomy.

Summary

A case is reported in which gross hematuria occurred following subcutaneous injections of hexamethonium bromide and eight months later after oral treatment with pentolinium tartrate. The patient had previously been subjected to unsuccessful surgical sympathectomy. The renal bleeding stopped promptly without treatment after each drug was discontinued.

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Acute Renal Failure

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MEREDITH MALLORY, M.D.
FRED MATHERS, M.D.
AND
W. DEAN STEWARD, M.D.
ORLANDO

Acute renal failure is a term selected by Homer Smith to describe the abrupt cessation of renal function resulting in a self-limited period of azotemia terminating eventually in practically complete functional recovery or death. In general, this picture is best known as lower nephron nephrosis, a term coined by Lucke in his classic description of the syndrome in 1946. Microdissection of individual nephrons by Oliver has since shown that the term is a misnomer. The syndrome, however, will probably continue to be known as lower nephron nephrosis, at least until clarification of the pathogenesis enables a more precise definition.

During the London blitz of World War II, the occurrence of large numbers of crushing injuries terminating fatally one to two weeks later, not because of the injuries but because of uremia, stimulated Bywaters in England and later workers in this country to investigate the pathogenesis of this renal lesion.

Etiology

A wide variety of clinical states are known to produce the lower nephron syndrome. The most common precursors are shock and transfusions, singly or, as often occurs, in combination. Intravascular hemolysis brought about by incompatible transfusion, burns, intravenous distilled water, hyperthermia and blackwater fever, and myohemoglobinemia as occurs in crushing injuries, forms a large group in which pigment excretion seems to be the common denominator. Acute renal failure also may supervene during the course of severe liver damage, the so-called hepatorenal syndrome. Sulfonamide intoxication may cause oliguria or anuria due to a hypersensitivity reaction with renal ischemia and subsequent damage, or result in the precipitation of crystals which form mechanical blockade. Chemical poisons such as carbon tetrachloride have a nephrotoxic action. Severe infections, hemorrhagic fever and severe gastroenteritis, usually when associated with shock, are known to produce acute renal failure. Sensitivity reactions such as severe anaphylaxis may cause this syndrome.

The predominant pathologic feature is tubular necrosis and tubular regeneration or repair. The lesions are distinctly spotty in their distribution. Any portion of the nephron may be involved, and rupture of the basement membrane is a common finding. After the fourth or fifth day, evidence of repair is present with the laying down of a flat endothelial-like layer of cells. These later become cuboidal, and if the continuity of the nephron has not been disturbed, regeneration may be complete.

The mechanism underlying this tubular injury is not so clear. The relative importance of the role played by pigment excretion and that played by renal ischemia each has its advocates. Evidence to date is in favor of renal ischemia as the most important single precursor of this disease. Most of the clinical states leading to acute tubular necrosis are accompanied by shock. Lawson, Bradley and Cournaud clearly demonstrated the effect of shock on renal hemodynamics in man. Renal blood flow and glomerular filtration rate are reduced in practically every case when shock is present. This reduction is associated with a pronounced increase in renal resistance, indicative of renal vasoconstriction. These data indicate that during shock renal vasoconstriction occurs, shunting blood from the kidney to perfuse other parts of the body. Just how long one can tolerate renal ischemia before renal damage occurs is not known for man. Experimental data from animals would indicate that one and a half to three hours of complete renal ischemia is the critical limit; however, evidence seems to indicate that the human kidney is somewhat more susceptible.

The frequent association of intravascular hemolysis and pigment excretion with acute renal

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failure has led many observers to place an etiologic function on hematogenous cast formation in the renal tubules. Evidence to support this view is lacking. Experimentally in animals and man, large quantities of pigment have been tolerated without renal damage. Flink has shown in dogs that when enough pigment is given, uremia will result, but the amounts he used would be equivalent to hemolysis and over 1 liter of blood in man. Pigment excretion has proved injurious when associated with dehydration or shock, conditions which greatly lower the filtration rate. This would lead to reabsorption of a greater proportion of water in the proximal tubule and the delivery of a smaller volume of urine to the distal tubule. This reduction in urine flow would facilitate the precipitation of the pigment and cast formation. Cast formation, however, does not occur in the proximal tubule, but only in the ascending limb of Henle's loop, the distal convoluted tubule and collecting tubules. It would seem, then, that cast formation plays a secondary role in the production of lower nephron nephrosis, being due in part to the reduced filtration rate which accompanies renal ischemia. Those who would disregard the importance of casts, however, should heed the words of Oliver, who pointed out a fact that every plumber knows, that water cannot flow through plugged pipes.

Clinical Picture

The clinical picture of lower nephron nephrosis is that of acute renal failure with progressive azotemia. Within a few hours after the precipitating cause, severe oliguria is observed. While this is characteristic and is usually the basis of an early diagnosis, it is not always present. We have seen patients who maintained an output of 1 to 2 liters a day throughout the duration of the lower nephron nephrosis. This observation also has been made by John Merrill and his group in Boston and Arthur J. Merrill of Atlanta. Characteristically, though, the urinary output falls to less than 400 cc. a day for a variable period up to 23 days with the average around 10 to 12 days. We should like also to emphasize the fact that if anuria exists, that is, no output at all, one should question the diagnosis of lower nephron nephrosis since it is usually not associated with persistent anuria. At the onset, the urine is frequently dark and bloody. It contains albumin, casts, and numerous red and white blood cells. The specific gravity is low, usually 1.010, and it is acid. Examination of the blood at this stage is apt to reveal nothing unusual unless there has been intravascular hemolysis. The patient is suffering more from the primary disease at this point, and no characteristic symptoms are observed, although vomiting is frequently present.

During the oliguric phase, there is a steady daily rise in the nonprotein nitrogen or blood urea nitrogen. Along with the nitrogen retention, sulfates and phosphates are retained, and an acidosis supervenes with a reduction in the serum bicarbonate. For reasons not completely understood, there is a rapidly developing anemia with hemoglobin dropping to 7 or 8 Gm. in many cases. Attempts to correct this anemia by transfusion have not been successful, and since transfusion has frequently led to fatal pulmonary edema, it is contraindicated unless the patient is actively bleeding. If the patient is not overhydrated, he will be mentally clear at this stage. If too much fluid is given, he will be lethargic or frankly disoriented. Signs of an increasing blood volume will appear. Hypertension is most often due to hypervolemia. Edema occurs with overhydration, and in the past the most common cause of death in the oliguric phase has been pulmonary edema.

We saved the problem of potassium intoxication until last since this complication deserves the emphasis of special consideration. At present, the rise of potassium is not completely understood though two obvious factors are (1) tissue breakdown with release of potassium, while (2) the route of excretion via the kidneys is closed. It is impossible to predict the rate of rise or to know just when during the course of the disease the concentration will reach a toxic level. This uncertainty then predisposes to close and careful following of the patient, both by daily serum potassium determination and by electrocardiogram. Clinical manifestations of potassium intoxication are mainly related to the cardiovascular and neuromuscular systems. These include faint heart sounds of poor quality, a falling arterial pressure, bradycardia, arrhythmias and finally cardiac standstill. The patient will appear anxious, restless and apprehensive, and progression leads to stupor and convulsions. Reflexes are at first hyperactive, become hypoactive and then absent. Paresthesias are common, and weakness soon leads to paralysis. These, however, are terminal signs and should be avoided if possible. The electrocardiographic changes are characteristic.

Animal experimentation shows that in dogs the earliest of the electrocardiographic changes

is a tenting or peaking of the T waves. This is followed by a depression and shortening of the ST segment and a gradual merging of this segment with the upstroke of the T wave. P waves are lost, and the QRS is spread. There is a decline in the height of the R waves with a deepening of the S waves. Further progression leads to disruption of the complexes and a sine wave type of tracing and eventually asystole.

Therapy

Management of patients with lower nephron nephrosis has evolved considerably since World War II when many of the patients with this disease were drowned by excessive fluids. Renal denervation and renal decapsulation had their heyday and have been discarded along with other ineffective methods.

Present day therapy is based upon the regulation of fluid balance and nutrition in order that the patient may survive until the kidneys are able to reconstitute themselves.

The average person at basal conditions will lose approximately 700 cc. of fluid by way of the skin and lungs, and this loss will constitute the bulk of the insensible fluid loss with maybe an additional 50 cc. a day with normal bowel actions. Thus the daily fluid requirement would be 700 to 750 cc. daily with additional allowances given only to replace urinary output and actual losses by gastric suction, diarrhea, fistulas, excessive sweating, and other means, should any of these be present. If the patient is vomiting, this fluid should be given intravenously as 20 to 25 per cent glucose in distilled water in an attempt to maintain nutrition. The glucose should be covered by regular insulin, 1/2 unit per gram, in an attempt to maintain serum potassium at normal or near normal levels. If the patient is not nauseated or vomiting, one may use fat and carbohydrate mixtures by mouth or tube. By reducing protein breakdown, one reduces urea formation as well as sulfates, phosphates, and potassium released by its catabolism.

No salt is given except to replace losses which may occur when gastrointestinal secretions are being lost. The serum sodium may drop to quite low levels. It is believed that this drop is usually due for the most part to hemodilution and the serum sodium can best be raised by fluid restriction rather than the administration of a sodium salt.

Toxic substances such as protein, potassium-containing substances such as fruit juice, magnesium and acid salts should be rigorously avoided.

Materials ordinarily excreted by the kidney, such as the antibiotics streptomycin, Aureomycin and others, should be used in much smaller doses.

Vitamin supplements are given daily.

Usually no attempt is made to correct the acidosis that nearly always occurs, since the administration of sodium bicarbonate is hazardous and the value of such a procedure has not been evident.

As pointed out earlier, the oliguric phase is variable, but averages 10 to 12 days. It is amazing but nevertheless true, that of the patients dying with lower nephron nephrosis, 25 per cent do so in the postoliguric or diuretic phase. This should emphasize the importance of conservatism and continued close following of the patient through this phase. As the diuretic phase is ushered in, the urinary output increases by 200 to 300 cc. a day at first and then more rapidly, so that soon the output may reach several liters a day. It is important to realize that renal function is still impaired at this stage as evidenced by the fact that most patients will continue to have a rising nonprotein nitrogen and blood urea nitrogen despite adequate urinary volume. The amount of salt which this urine contains will vary and must be carefully followed so that replacement can be intelligently pursued. Potassium and/or calcium depletion may occur and should be watched for. As acidosis is corrected, a lowered serum calcium may precipitate tetany.

By following such a program, most patients can be carried through seven to 14 days of renal shutdown.

In some patients, however, dangerous serum potassium levels will begin to develop despite glucose and insulin as recommended earlier. Potassium-removing resins should be used, and if ineffective, then these patients are candidates for a more dramatic form of therapy, namely, artificial dialysis. Gastrointestinal lavage and peritoneal lavage have been used with good results in some cases, but there are several disadvantages to each, and the mechanical or artificial kidney is by far the safest and most effective means of treatment. In general, artificial dialysis is indicated when serum potassium reaches 7 to 8 milliequivalents per liter and actually many times before these levels are attained. That is when the patient has clinical or electrocardiographic evidence of potassium intoxication regardless of the blood level. Then, too, the serum sodium would

be important, for a serum potassium of 7.0 milliequivalents would be less dangerous with a sodium level of 140 milliequivalents than with one of 120 milliequivalents. Another factor which would influence one in deciding upon dialysis would be the urinary output. If it appears that the output would reach or exceed 500 cc. a day within another 24 hours, one might temporize with an otherwise dialyzable patient. Dialysis is never indicated for uremia as such.

Conclusion

The historical, pathogenic and clinical aspects of acute renal failure are reviewed, and a conservative form of management is outlined. It is emphasized that good clinical judgment, based on experience and a thorough understanding of the disease, is imperative in the management of acute renal failure.

12 East Sturtevant Avenue.

Discussion

Dr. William J. Dean, St. Petersburg: I certainly enjoyed Dr. Freeman's paper. The subject is most interesting today since the concept of treatment of acute renal shut-down is somewhat different than it might have been a few years ago. Dr. Freeman covered the subject rather completely. I shall emphasize a few points that he made, placing most of the emphasis on the cardiovascular system.

After oliguria begins, the main danger, or the most common complication, is congestive heart failure. Some of you may be raising an eyebrow about the use of the term congestive heart failure here. It really does not matter whether you use that term or not, but actually the patient with acute renal failure will have all of the symptoms that one usually associates with congestive failure. True, he may have no evidence of cardiac damage beforehand. The electrocardiogram will be normal, and all of the tests will be normal. If one were going to be a real purist, he should call it hypervolemia, I presume, but the patient still will have all of the signs and symptoms that one usually thinks of — the edema, the pulmonary edema, as Dr. Freeman mentioned, and all of the other symptoms one usually associates with congestive heart failure. I think early recognition is important because this is the time when one must remember to restrict the intake markedly, as has been pointed out.

Next, I shall say just a word concerning hyperkalemia versus potassium intoxication. They are the same, and yet maybe there is a difference in degree. The symptoms that Dr. Freeman mentioned referable to the cardiovascular system, such as pulse changes, irregular rhythm and blood pressure changes, all really are associated with potassium intoxication. Why even make this distinction? Usually, or let me say I hope it is usually, there is some warning, or one has some idea that there is a hyperkalemia or elevated potassium before the full blown signs and symptoms of potassium intoxication manifest themselves. Dr. Freeman pointed out, and I believe Dr. Merrill and some of his group in Boston first showed that the sodium level is most important. If there is hyponatremia, or low serum sodium and acidosis, the electrocardiographic changes, and the clinical changes as well, are apt to be more pronounced with the same serum potassium level. For this reason it is important to know the level of the serum sodium and the carbon dioxide combining power.

With regard to the electrocardiogram, Dr. Freeman showed a slide of a dog which certainly is characteristic. He also made the remark that as one is following patients with this disease, it is important to obtain an electrocardiogram and to determine serum potassium levels daily. He certainly is right. It is confusing at times if one does not realize that these two determinations may not seem to correlate. The electrocardiogram may be definitely showing the peaked T waves while the serum potassium may not be markedly elevated. It is not known how to explain this lack of correlation completely. One theory has been that the electrocardiogram in this case is reflecting the intracellular potassium. I am not sure whether this is right or not, but I think that it is important to use either one, if they do not agree. If the electrocardiogram shows pronounced signs of potassium intoxication, then that is important even though the serum level may not agree. On the other hand, if there is what appears to be a normal electrocardiogram, but serum potassium levels are elevated, then there again this is important. If one has carried out all the steps that Dr. Freeman has mentioned and still is confronted with either one of these signs, then he should be thinking about the artificial kidney or some other dialysis measure.

Dr. Joseph H. St. John, Jacksonville: It would be superfluous for me to try to add to the excellent summary that already has been given, but I shall express a few personal thoughts. This problem of lower nephron nephrosis represents an important addition to the list of kidney diseases which just within the last 10 years have become subject to cure. Not only should the fields of microbiology, antibiotics, cancer detection and treatment, hormonal therapy, poliomyelitis with its great strides, and the prevention and treatment of heart disease share the limelight of progress in medicine, but the continuing study of the kidney and its afflictions has come a long way by the use of routine laboratory tests of the various electrolytes and the understanding of electrocardiographic changes in electrolyte disturbances.

The essence of treatment of acute renal failure is prevention of overtreatment and control and constant vigil of the patient on the physician's part. It is not a simple problem of seeing the patient once a day. It is a problem of living with the patient until the emergency is over, which may be 23 days or longer. The laboratory technician and the electrocardiographic technician should be called on not merely once a day but perhaps four, five or six times in a 24 hour period. The work is hard, the vigil constant, but the results most gratifying.

The scientific program for the 16th annual Medical District Meetings of the Florida Medical Association is published in this issue of The Journal on page 309.

Treatment of Varicose Veins of the Lower Extremity by Stripping

JAMES R. ANDERSON, M.D.
WEST PALM BEACH

It is the purpose of this paper to present a method of treatment of varicose veins of the lower extremity which I and others believe to be far superior to the formerly employed technic of ligation and injection. This newer technic has been termed vein stripping. The procedure will be described for those who are unable to see the motion picture.

Patients seek treatment of varicose veins for several reasons. These may be outlined as follows:

1. Cosmetic appearance
2. Symptoms of uncomplicated varicosities
 a. Heaviness
 b. Soreness
 c. Aching
 d. Cramps in legs
3. Complications
 a. Rupture
 b. Thrombosis and thrombophlebitis
 c. Stasis dermatitis and ulceration.

The cosmetic defects are well known to everyone and seldom bother men.

I cannot explain why some people with large veins do not complain of symptoms, while others have definite complaints of mild soreness along the veins, and heaviness and tiredness of the legs in the latter parts of a day. I never promise that vein surgery will stop night cramps, but I suggest that the wearing of adequate elastic support will give some indication of what can be expected of an operation. A 4 inch rubber elastic bandage (such as an Ace No. 8), applied from the toes to the knee, will eliminate much of the fulness, tiredness, and slight edema which occur from incompetent veins. This measure will help patients to decide whether or not they desire treatment if there is some difficulty in arriving at a decision in cases of early incompetency or minimal vein size or symptoms.

Complications of Varicose Veins

Complications of varicose veins include those in the vein itself and those of the leg. The veins are subject to (1) spontaneous thrombosis, and (2) rupture with bleeding. Chronic incompetence of veins leads to edema with stasis. Stasis leads to dermatitis and ulceration and/or pigmentation.

Stasis dermatitis with its itching, weeping skin surface is a most distressing condition. It is frequently treated for many months with salves and lotions with no thought being given to the underlying venous stasis and edema of the skin, which can be cured either by surgery, temporary adequate support, or bed rest with elevation.

Open sores or ulcers are observed frequently. I prefer that these be healed before vein stripping is attempted. They can always be healed, and usually without skin grafting, with proper elevation and dressings.

Previous deep thrombophlebitis is not a contraindication to treatment of superficial varicosities by stripping. If the patient gets some relief from wearing an elastic bandage, he will be helped by surgery. No special tests other than that are performed to test deep circulation. The varicosities which appear after deep phlebitis may be channels for collateral circulation at first, but these are incompetent superficial varicosities of no value when the femoral vein has been recanalized. Edema of the leg may still be present after vein stripping, and the patients in such cases may always require some elastic support, but it can usually be lighter than before stripping.

Evaluation of Veins Preoperatively

Evaluation of veins prior to stripping is made with the patient standing up. Special attention is paid in all cases to the lesser saphenous vein. This vein requires surgery in approximately 20 per cent of legs operated on, and its recognition is the most important feature of the preoperative examination. The vein courses under the thin enveloping fascia at the back of the knee before entering the popliteal vein. Its origin is at the lateral border of the foot and behind the lateral malleolus. Two methods help in its identification as an incompetent vein. The percussion-palpation maneuver transmits an impulse up or down the entire length of the vein. Because of valves

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it is rarely possible to send an impulse down a normal vein, but this is easily done in cases in which veins are incompetent. Another useful method is combined with tourniquet evaluation of the greater saphenous vein. The patient's leg is elevated and a tourniquet placed above the knee on the thigh. The patient stands up. The veins are inspected and palpated. If incompetency is only in the greater saphenous vein at the groin, no veins will be seen or palpated immediately, although the lesser saphenous vein will fill and be visible or palpable on the back of the calf or lateral ankle region during this tourniquet test. The test is then repeated; this time the examiner holds his thumb over the popliteal space, compressing the upper segment of the lesser saphenous vein as the patient stands. This procedure effectively prevents filling of the lesser saphenous vein and establishes a diagnosis.

Incompetent perforating branches of the greater saphenous vein are looked for during the tourniquet test. If any segment of the greater saphenous vein fills immediately when the patient stands with a tourniquet on his thigh, the incompetent perforating veins are present. Moving the tourniquet lower on successive repetitions of the test eventually will help to locate these communicating veins so that they may be marked for individual ligation at the time of surgery.

The afternoon or evening before operation, the patient's legs are inspected and palpated. Tourniquets are used when necessary to locate perforating veins. The incompetent veins are marked by a scratch on the skin of the foot below the internal malleolus and at the knee so that incision may be made directly over the vein.

The operation is usually performed with the patient under general anesthesia. The patient's legs are prepared by washing with soap and water and the application of ether, alcohol, and one of the mercurial or other suitable skin antiseptics. The toes are covered with a rubber glove. When the operation on the greater saphenous vein is performed, Pentothal Sodium, nitrous oxide and oxygen are the anesthetic combination of choice for the entire procedure, and the patient lies supine.

Greater Saphenous Vein Operation

The operation for the greater saphenous vein begins with a dissection of the saphenofemoral junction at the groin in an ordinary fashion, with ligation and division of all branches widely. The saphenofemoral junction is doubly ligated flush with the femoral vein. Small branches entering the femoral vein in the vicinity of the junction are ligated and divided by choice. The distal end of the saphenous vein in the groin is clamped and not ligated.

The next incision is made on the foot near the ankle over the palpable saphenous vein. The saphenous vein at the foot is dissected free of its nerve and clamped and divided. The distal end is tied. The proximal end is held, and a hole is made near the clamp into the side of the vein large enough to introduce the tip of the stripper into the lumen. More often than not, the tip will pass from foot to groin without difficulty. Occasionally it will pass only to the knee because of tortuosity of veins. In the latter eventuality, another stripper is introduced at the groin and passed distally into the saphenous vein. This usually will meet the other stripper, and both small ends can be obtained through one incision. Customarily I make an incision on the posteromedial aspect of the knee and examine the saphenous vein in this location for branches before stripping. If branches are found, they are clamped and divided. These may be ligated, or held for an attempt at stripping later.

When the preceding steps have been completed, the vein is removed by pulling on the stripper. The large knob prevents the vein from turning inside out. It usually telescopes the vein on itself as it is pulled through the subcutaneous fat, and the entire vein may be removed through the other incision. If the vein appears with an intact branch, this is clamped and divided. Most branches tear off and retract. At this stage it is wise to apply pressure for two or three minutes with a folded towel over the vein channel and to elevate the feet 10 or 12 inches. A special hinged ratchet board, under the mattress of the operating table, can be used for this, or the table may be placed in Trendelenburg position. Bleeding usually is minimal. If bleeding is excessive, it may be necessary to pack gauze into the channel temporarily, or even to open the channel for ligation of a branch, but this procedure is rarely required. Clots should be milked from the channels before wound closure.

Large branches and accessory saphenous veins are either avulsed with forceps after blunt subcutaneous dissection, stripped out, or ligated for later injection. As many large varices as possible should be removed rather than left for injections.

Occasionally large masses of veins are dissected en bloc through incisions 4 or more inches in length. Most patients with severe varicose veins do not object to scars in place of veins; they are told of the possibility of direct dissection before the operation.

Closure of wounds is performed with interrupted vertical mattress sutures of 3-0 silk in the skin. At the groin, subcutaneous 00 plain catgut is used, and the skin may be closed with a continuous suture in most instances.

When the patient returns to bed, the foot of the bed is elevated to 30 degrees. Fluids and diet are allowed as soon as the patient recovers from anesthesia. No walking is done the day of the operation, but the following morning all patients begin walking four minutes of each hour. They are dismissed from the hospital 48 hours after the operation. Most patients do not complain of pain, or, at most, they state there is a slight burning sensation at the groin.

After stripping has been performed, the patient visits the office for removal of sutures and closure by injections of any branches which remain filled with blood and palpable. Usually few injections are needed.

Lesser Saphenous Vein Operation

When the lesser saphenous vein is incompetent the operation is usually started with the patient lying prone. It is possible to perform the popliteal dissection with local infiltration anesthesia induced by a 2 per cent solution of procaine hydrochloride. The inhalation of nitrous oxide and oxygen is sufficient for amnesia for the brief period of the stripping of the lesser saphenous vein. In this way it is feasible to avoid the use of an intratracheal tube and still have the patient lying prone.

The skin incision for the lesser saphenous vein is made transversely in the middle of the popliteal space. When the subcutaneous fat has been divided down to the fascia, it is pushed proximally and distally so that the fascia may be incised at a right angle to the skin incision. Only after incision of the fascia is the lesser saphenous vein available for dissection. It is followed down between vessels and nerves by blunt dissection, ligated flush with the popliteal vein, and divided. Another incision is made behind the lateral malleolus and the lesser saphenous vein dissected, clamped and divided. The stripper may be passed from the foot to the knee in almost all cases, and the vein is easily stripped out. The fascia at the knee is closed with interrupted chromic 00 catgut, and the remainder in the usual manner.

Bandages are placed on each incision with elastoplast, and folded combination pads are laid along the course of the vein channels. The entire extremity is then wrapped lightly with No. 8 Ace Bandages, 4 inches in width.

Results

All patients with varicose veins operated on in this manner have been helped. All have been pleased with the result. There have been no unusual complications and no pulmonary emboli in my own patients.

421 Pan-A Building.

Discussion

DR. DONALD W. SMITH, Miami: I want to congratulate Dr. Anderson on this excellent film. I think it is technically beautiful and very clear. I am not one to discuss a paper on stripping because I do not do it routinely. I still believe that there are indications for high ligation and interruption of the incompetent perforators and then postoperative injection of areas of stasis failing to thrombose spontaneously. I do not agree with some that there is no place for injection and no place for stripping, and that the saphenous system should be dissected through multiple short transverse incisions. Stripping certainly has its place and should be used wisely.

The preoperative examination is most important in the success of surgery for varicose veins. When one is not stripping the veins, it is necessary to be accurate in locating these incompetent perforators. The patient must be examined after having been on his or her feet for some period of time so that these deep veins that are incompetent are incompetent when examined. This is not always the case when one examines a patient who has just gotten out of bed. I believe that when a high ligation is done, it should be complete. One should look for anomalous veins most carefully.

Stripping obviously eliminates the perforators. It also eliminates the large vascular bed frequently left as an annoying mass of thromboses after simple ligation. In many of my cases, I am unable to run the stripper through as nicely as Dr. Anderson has shown. I encounter masses of veins in the leg and around the medial aspect of the knee, which must be dissected. Stripping saves considerable time in their removal although bleeding may be plentiful. Tilting the table to elevate the legs and applications of pressure dressings will usually control the profuse bleeding although I prefer to ligate them individually if they can be located. Occasionally I have found some exceedingly long branches and have wondered if perhaps I were pulling some perforators out of the femoral vein, leaving damage to the deep circulation which might result in deep venous thrombosis and thus might explain the occasional case of postoperative edema.

I think it is definite that the pendulum has swung back to stripping. Twenty years ago surgeons were doing some stripping, and now we are back to it again but with a more rational approach, by combining a careful examination with stripping and dissection.

DR. JOHN J. FARRELL, Miami: I should like to congratulate Dr. Anderson on a beautiful presentation. I agree with him that stripping is probably the most definitive procedure that we have. I do not think that you can categorize patients with varicose veins, and along with Dr. Smith I think there are some in whom you cannot limit treatment to high ligation and multiple liga-

tions; you have to resort to stripping along with ligation. At times in stripping, to answer one statement that Dr. Smith made, there are many of the long-standing varicose veins that you can set out to handle easily with inside stripping and then you still can get into trouble. In those instances use the old outside Mayo stripper, and that will take care of the tortuous veins.

With regard to postoperative edema, I believe that all patients subjected to stripping procedures should be made to wear Ace Bandages for at least a month, preferably six weeks, postoperatively, for by so doing they will bypass most of the edema. Actually the most important consideration on varicose veins really is not to allow veins to be of such long standing that stasis dermatitis, stasis eczema and ulcers occur. If more veins were treated earlier, the end result would be much better than at present, and for that reason we ought to take a much more vigorous attitude toward the treatment of varicose veins.

Trichomonal and Mycotic Vaginitis Controlled with Baculin and Amfrecin

Eduardo F. Peña, M.D.
Miami

"The most vulgar denominate the discharge 'the whites'." Thus Clarke[1] wrote in 1814 concerning "the most frequent complaint to which women are liable" — the condition he and his contemporaries called fluor albus or fluor muliebris. In 1836 Donné reported to the French Academy of Sciences his discovery of a microscopic organism in purulent secretions from the male and female genital organs. This "infusorial" organism he named Trichomonas. His discovery attracted little attention until 1855 when Kolliker reported finding the organism in 50 per cent of the women he examined.

All patients examined for the causative factor of vaginitis should be scrutinized carefully for cervical lesions, which must be considered precancerous until disproved by biopsy. In a large percentage of cases of carcinoma of the cervix there is a history of vaginal infestations of long standing. It is axiomatic that cervicitis and cervical erosions must be corrected immediately regardless of the age of the patient.

Numerous authors have reported the ubiquitous nature of the trichomonad, not only in the vagina, cervix, vulva, urethra and even the bladder of the female, but also in the preputial sac, urethra, prostate, seminal vesicles and bladder of the male. It is now known that 80 per cent of vaginal inflammations and of leukorrhea are caused by Trichomonas.[2] Davis[3] found some type of discharge in one third of a group of 1,000 gynecologic patients.

From the Department of Obstetrics and Gynecology, Mercy Hospital, Miami.

*Amfre Drug Co., Inc., New York. Each Baculin Vaginal Tablet and each gram of Baculin Vaginal Powder contain diiodohydroxyquinoline 100 mg., phenylmercuric acetate 3 mg., sodium lauryl sulfate 3 mg., lactose 430 mg., dextrose 430 mg., aluminum potassium sulfate 14 mg., and papain 20 mg.

**Amfre Drug Co., Inc., New York. Each teaspoonful of Amfrecin douche powder contains sodium lauryl sulfate 12.5 mg., papain 50 mg., citric acid 0.8 Gm., actose 4.1 Gm., methyl salicylate 12.5 mg. and menthol 12.5 mg.

As the trichomonad is transferred by body to body contacts, it is commonly found in girls' orphanages, old ladies' homes, and among mothers and daughters who exchange articles of clothing. It is most frequently transmitted by sexual intercourse.

Diagnosis

The wide prevalence of trichomonal infestation makes it important to the general practitioner as well as to the gynecologist. It is therefore desirable that a simple and efficacious therapy be available and that the family doctor learn to diagnose the condition when he encounters a case of leukorrhea. Since the majority of cases of leukorrhea are caused by Trichomonas, he should suspect this cause and look for the organism under the microscope — either a stained or unstained specimen. Most of the cases of leukorrhea not due to Trichomonas are caused by the fungus Candida albicans, and the remainder by a score of species of organisms, including staphylococci, streptococci, pneumococci, micrococci, the Ducrey bacillus and the gonococcus.

The vaginal speculum should be inserted without lubricant, since acid jelly lubricants immobilize the trichomonad. With a cotton swab material is transferred from the fornices to a small quantity of Ringer's solution. The organism is easily identified by its flagella and undulating membrane. This method together with the smear stained with the conventional Papanicolaou stain will identify the trichomonad in practically every case.[4] It is rarely necessary to culture the organism for its identification, but it grows well in practically all nutrient mediums containing blood or serum.

Fortunately for the practitioner, now that

broad spectrum antivaginitis remedies are available, it is seldom necessary to determine the actual specific causative organism.

Symptoms

The discharge in trichomonal vaginitis is yellowish, foul in odor, frothy and bubbly. It is highly irritating to the vulva and the skin on the inner sides of the thighs. There is intense itching and burning of the vulva and the vagina. Small petechiae may be seen on the vaginal walls. The discharge from an infestation of the vagina by Candida is highly irritating to the vulva, but does not scald the inner aspects of the thighs as does that from Trichomonas. Many women harbor silent infestations of Trichomonas, and rarely does the organism give symptoms in the male.

Treatment

It often has been said that when there is a host of varied therapeutic regimens and products for a disease, none of them is satisfactory. Up to a few years ago this observation was true of Trichomonas vaginitis. Picric acid, arsenic, mercury and silver compounds, iodine, aniline dyes, sulfonamides, antibiotics, vaccines and hormones[5] all have been found wanting.

The difficulty with these older forms of treatment was that, although they might be effective trichomonacides in vitro, they did not suffice for the conditions under which the organism is found in the vagina — under a protective albuminous layer, in crypts, rugae and glandular ducts. No single substance could be effective since several objectives must be accomplished simultaneously.

I have yet to see a vaginal cream that is generally effective against infestations of Trichomonas and Candida. I now employ a most effective product, Baculin, which has been used in the 200 cases reported here. This product[6] contains, as its effective trichomonacide, a combination of the two most active compounds against Trichomonas and Candida, diiodohydroxyquinoline and phenylmercuric acetate, thus making it a veritable broad spectrum antivaginitic. The detergent, sodium lauryl sulfate, is added as a wetting agent to insure penetration of the antiseptics through the protein barrier and into the crypts, rugae and glandular ducts. Papain in the formula digests the mucus and liquefies the protein coating which protects the pathogenic organisms from the remedy.

The most effective measure against trichomonal infestation is maintenance of vaginal hydrogen ion concentration at approximately 4.0, the optimal acidity for a normal vaginal flora of Doederlein bacilli. This is accomplished by added aluminum potassium sulfate as a buffer. Lactose and dextrose further favor the nutrition of the normal flora, and the production of normal quantities of glycogen deposited in the normal vaginal epithelium.

Antibiotics have been found to be generally ineffective in the treatment of vaginitis.[7-9] In fact, they interfere with the normal vaginal bacterial flora and predispose to fungal predominance, largely Candida, leading to pruritus vulvae and ani.

Therapeutic Regimen

In the present series of 200 cases of vaginal discharge the following routine was used:

OFFICE ROUTINE. — After thoroughly flushing with an antiseptic solution and drying the vagina with cotton, and an electric hair dryer, I insufflate 1 ounce of Baculin powder through a speculum, making sure to cover the entire surfaces of the vagina, cervix and vulva, and ballooning the vagina to iron out the folds and rugae. This procedure invariably gives immediate relief from burning and pruritus.

HOME TREATMENT. — Instructions are then issued for treatment at home as follows:

Insert 2 Baculin tablets into the vagina each night and morning, stoppering the vagina with a pledget of cotton. Return for office treatment twice a week. Before and after intercourse, douche with the Amfrecin powder, 1 teaspoonful to 1 quart of warm water followed by insertion of 2 tablets into the vagina. Condoms must be employed until both husband and wife are free of organisms.

Alternating office and home treatments are continued through at least one menstrual period, preferably two or even three. During menstruation douching three or more times a day is recommended, with the usual insertion of 2 tablets and vaginal stopper afterwards.

Microscopic examination of vaginal secretions showed 98 per cent of the patients in this series to be free from Trichomonas and Candida after one month of this routine therapy. There were failures in 2 per cent due to lack of cooperation on the part of the patient or her husband. One husband refused to visit a urologist for treatment of a persistent trichomonal infestation of the prostate.

Enamel or stainless steel enema cans are to be preferred to the rubber douche bag. They can be drained dry to avoid development of mildew, molds, and bacterial contamination. The vaginal nozzle of the douche tube should be sterilized before each use. Formerly I advised the patient against forward use of toilet paper to avoid carrying Trichomonas from the bowel to the vulva and vagina; but recently it has been shown that Trichomonas intestinalis (or hominis) cannot grow in the vaginal environment. It is strongly recommended, but seldom heeded, that coitus be suspended during the entire course of treatment.

The most resistant cases in this series were those in which hysterectomy, or extensive cervical cauterization or conization had been performed, and those in which the patient was in the menopausal or postmenopausal period. A particularly persistent focus for reinfestation is the cervical stump.[10] All patients with reinfestation at this site required more careful and more intensive treatment. Reinfections probably occurred from the bladder, the cervical canal and Skene's ducts. The reinfections occurred most frequently during menstruation. Blood is apparently an ideal nutrient medium for Trichomonas.

Success with this therapy has encouraged its use not only in the usual forms of vaginitis with discharge, but also in senile vaginitis after excluding diabetes as its cause, in postpartum vaginal hygiene, and preoperatively and postoperatively in cervical and uterine surgery. This routine is effective in control of vaginal, vulvar and perineal irritation from malodorous puerperal discharges. Postpartum patients are instructed to use this therapy from the third week following delivery until their office check-up six weeks postpartum.

During pregnancy insufflation should be avoided, although Baculin vaginal tablets and douches at low pressure with Amfrecin may be employed. These treatments should be used during pregnancy for the minimum period required to control the vulvar and perineal irritation, the discharge, and the pruritus frequently so intense as to cause nervousness and insomnia. Pregnant patients need especially careful handling lest the condition become so severe that they require hospitalization.

Summary

Two hundred cases of vaginitis, largely trichomonal, were treated with Baculin, combining trichomonacides with supporting wetting agent, buffer, protein digestant and nutrient carbohydrates, and Amfrecin douches containing wetting agent, protein digestant, acid, carbohydrate and soothing, cooling antipruritics. In 98 per cent of these cases there was freedom from infestation after one month of treatment. This therapy was extended routinely to include use in preoperative and postoperative treatment in gynecologic surgery, in prepartum and postpartum vaginal hygiene, and in senile vaginitis with excellent results.

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Approved Substitutes for One Per Cent Silver Nitrate For Prevention of Ophthalmia Neonatorum

The Florida State Board of Health has announced the approval of two preparations to be used by physicians as substitutes for 1 per cent silver nitrate for the prevention of ophthalmia neonatorum.

The substitutes are tetracycline ophthalmic ointment 1 per cent, or equivalent, and erythromycin ophthalmic ointment 1 per cent, or equivalent. Oxytetracycline (Terramycin) and chlortetracycline (Aureomycin) are included.

This action was taken pursuant to authority vested in the State Board of Health by Chapter 383.04 Florida Statutes, which provides that a 1 per cent solution of silver nitrate or other effective prophylactic approved by the State Board of Health be instilled into the eyes of every child at birth.

It should be emphasized that these substitutes for silver nitrate are approved for use only by physicians in hospitals. Midwives and those doing home deliveries are required to use 1 per cent silver nitrate.

The Ehlers-Danlos Syndrome Report of a Case

JACK W. FLEMING, M.D.
PENSACOLA

The Ehlers-Danlos syndrome[1,2] is an unusual clinical condition affecting the skin and skeletal systems. Features of the syndrome are:[3] (1) hyperelasticity of the skin, (2) fragility of the skin and blood vessels, (3) pseudotumors over bony prominences, related to skin fragility and trauma, and (4) hyperlaxity of the joints. Added to this tetrad more recently is (5) movable nodules beneath the skin of the extremities and buttocks.[4-6] Many congenital defects of varying types have been reported in association with the syndrome. Although the complete syndrome is reported to be rare, it is likely that cases with portions of the syndrome (formes frustes) occur more commonly than is generally appreciated. Also, the severity of the manifestations vary among different persons and among members of a family.[7]

Johnson and Falls,[7] in an excellent review and study of the clinical and genetic aspects of this condition, stressed the likelihood of the incomplete syndrome. They urged that internists be more aware of this possibility in patients with ecchymoses and hemorrhages, that surgeons detect this condition in patients with friable skin, and that orthopedists consider it more often in persons with unstable joints.

Clinical Features

HYPERELASTICITY AND HYPERLAXITY OF THE SKIN (DERMATOCHALASIS, LAXITAS CUTIS).—The skin has a characteristic feel similar to velvet over soft sponge rubber. Its consistency has been described as like the peeling of a baked apple,[1] like a rubber band,[8] and like the skin over the eyelids of a normal person.[7] The subcutaneous fat seems minimal, so that bony prominences are easily palpated.[3]

The skin may be tented or pulled away as much as 6 to 8 inches, and wrapped around a finger or in accordion folds.[3] When released, it returns to place without rugae or wrinkles. Elasticity may be limited to a few areas of the body, to one side of the body, or to the mucous membranes.[9]

FRIABILITY AND FRAGILITY OF THE SKIN (DERMATORRHEXIS, FRAGILITAS CUTIS).—Ronchese[10] stressed that fragility of the skin is usually one of the most prominent features of the syndrome. The patient may have repeated lacerations due to the slightest trauma. Because of the elasticity of the edges of the skin, small wounds may gape and cause difficult healing. Bleeding from the wounds is usually not a prominent feature because of this contractility of the edges of the wound; however, hematomas and ecchymoses are common because of fragility of the small vessels and supporting tissues. Blood coagulation studies have been normal, but there have been reports of excessive bleeding associated with trauma, tooth extractions, tonsillectomy and pregnancy.[7,8]

It should be noted that cutis laxa (in the India rubber man of the side show) differs from the usual case of the Ehlers-Danlos syndrome. In the former, the skin is tough, whereas fragility of the skin is a dominant feature in the Ehlers-Danlos syndrome.[11]

SCARS AND PSEUDOTUMORS. — The scars resulting from repeated trauma and unapproximated wounds are a characteristic and prominent feature of the syndrome. They are thin, wrinkled, papyraceous, and may resemble crinkled cigarette paper. They may be colorless or have bluish pink color; telangiectasia is often prominent. They are not adherent to the subcutaneous tissues and bulging or pedunculations of these scars result in the characteristic pseudotumors, which are found over the bony prominences, especially the knees and elbows.

HYPERLAXITY AND HYPEREXTENSIBILITY OF THE JOINTS (ARTHROCHALASIS, LAXITAS ARTICULARIS). — Severe forms of this characteristic may cause serious and disabling impairment of skeletal function, resulting in limitations in walking, standing, writing, and performing skilled movements. Subluxation and spontaneous dislocation of any of the joints are not uncommon. A person with this

feature of the syndrome may be able to place the arm behind the back and touch the ears with the fingers,[12] or touch the umbilicus with the heel of the foot.[13] The thumb is most commonly involved, and extension against the wrist may be easily possible.[7] Involvement of the joints of the feet may be manifested by third degree pes planus.[14] Less severe forms of this characteristic may cause no discomfort or disability and serve only as a source of amazement to those witnessing a performance.

Subcutaneous Nodules.—Spherules or small cystlike tumors are frequently palpable in the subcutaneous tissues of the extensor surfaces of the extremities and of the buttocks;[5,6] they probably result from trauma. These tumors range in size from that of a pea to a hazelnut.[7] They apparently are small, avascularized, budlike bodies of connective and adipose tissue which degenerate and become loose, movable nodules in the subcutaneous tissue. Calcification occurs in many of them, and this presents a characteristic roentgenologic picture: "In most instances, a central zone of relatively increased radiolucency is surrounded by a ring-like shadow of lime salt. Some of the nodules are faintly stippled and a few are entirely homogeneous, but these are in the minority."[6] These nodules are always superficial in location, whereas angiomatous phleboliths may be distributed through the deep tissues, may have concentric strata and vary more in size and regularity. Calcified larvae found in muscles as well as the other more common causes of soft tissue calcification are also usually not difficult to differentiate by roentgenogram.

Etiology

The etiology of Ehlers-Danlos syndrome is unknown. It may be familial or sporadic. There have been reports indicating that prematurity may be either a cause or an effect of this condition since in cases when only one child in a family manifested the syndrome, there was a history of prematurity in that affected person.[7]

This condition may be regarded as a congenital, constitutional and developmental mesenchymal dysplasia;[15] thus, the structures of ectodermal origin are affected only secondarily. Endocrine and metabolic disturbances have been suggested as etiologic agents, but there is little to support this view.

Genetics

Most reports indicate that this syndrome ordinarily is transmitted by a Mendelian dominant inheritance pattern; however, there are many reports of Ehlers-Danlos syndrome transmitted to affected offspring by normal parents. This transmission may be due to lack of penetrance of the gene (incomplete dominance), or the parents may actually have had a mild,, undetectable form of it.[7] Other genetic explanations for sporadic occurrence of this condition in persons with normal parents are as follows, according to Johnson and Falls:[7] First, the affected person may receive an abnormal gene from both parents; thus this represents an autosomal recessive form of the disease. Second, there may be sex-linked transmission of the gene, and the condition may be present in females over several generations before a male is affected. Third, the case may represent a mutation in the germ plasm of one of the parents of the affected persons.

Pathology

Reports of biopsies of the skin show a wide variation in the findings. For the most part, increases in the number or size of the elastic fibers or abnormalities in their arrangement or appearance have been reported;[12,14] however, some authors have reported normal elastic tissue, diminution in the collagen of the corium, and abnormalities of the appearance of the collagenous fibers.[7]

The epidermis shows wrinkling due to the contractile, underlying corium. Atrophy and blunting of the rete pegs may be present. Blood vessels have been reported to be tortuous, thick-walled,[16] and thin-walled.[3]

The pseudotumors show proliferating blood vessels and connective tissue, and giant cells.[10,17] The subcutaneous nodules have dense collagenous fibrous tissue capsules which contain some intact fat cells, but mostly necrotic and calcified fat.[6] Giant cells also may be present in the nodules.

Treatment

There is no specific treatment for this syndrome. Attention should be given to protection of the patient from trauma. Pressure bandages over ecchymoses or hematomas may prevent the formation of pseudotumors.[16] Smith[18] reported that in one patient injuries to the skin were diminished considerably with gain in weight, thereby increasing the subcutaneous panniculus. Control of bleeding is usually not a problem since the edges of the skin retract. Special care in suturing or the use of mattress sutures, metal clips, or adhesive tape may be indicated in the repair of lacerations of the friable skin. If sutures are removed at the usual time, adhesive tape may be necessary

for reinforcement to the healing wound. Hyperextensible joints may necessitate stabilizing supports, braces, or orthopedic surgery.

Report of Case

A 22 year old private entered the United States Army Hospital at Camp Hanford, Washington because of an open wound on the anterior aspect of the right leg. Following a trivial injury 12 days prior to admission, he had sustained a laceration on the right leg. This laceration was sutured at that time, and after five days the sutures were removed. Two days later the edges of the wound retracted, leaving a gaping, superficial wound. Secondary infection then developed in this site.



Fig. 1. — Photograph showing crinkled, predunculated scars of both knees. The healing, unapproximated laceration on the anterior aspect of the right leg is apparent.

The patient had always noted that his skin was soft, easily bruised and easy to cut. When he was 7 years old, a doctor commented that his skin was "as soft and as thin as tissue paper." He did not bleed excessively, but had sustained numerous cuts and bruises over his lifetime. He had not had difficulty with unstable joints.

He had had occasional headaches as long as he could remember. Aching in the proximal joint of the right thumb had recurred since an injury four years prior to admission. An appendectomy at 11 years of age and injuries to his head and knees in an automobile accident five years later resulted in no complications.

His mother had "heart trouble." His father had chronic backache. Seven brothers and four sisters also were living and all were well. One brother had had a "stroke" at 23 years of age, but there were no residuals. There was no history of skin similar to the patient's or hyperlaxity of the joints in any member of the immediate family or distantly related relatives, to the patient's knowledge.

On physical examination, the blood pressure was 118 systolic and 78 diastolic. The patient weighed 160 pounds and was 70 inches tall. He was a quiet, pleasant man of average intelligence. The general physical examination gave essentially normal results with the exception of the following findings: The gag reflex was absent. An epicanthus was noted on the right eye. His hair was soft and fine. The face was full and "round," and he had a rosy, smooth complexion. The skin over his entire body, but to a lesser degree on his hands and feet, was extremely thin,



Fig. 2. — Photograph showing pseudotumor on the left elbow.

"rubbery," hyperextensible and contractile upon pinching palpation. Flat palpation of the skin gave the sensation of feeling extremely soft, sponge rubber. Pedunculated, violet-colored pseudotumors were noted over the knees and elbows. Their surfaces were smooth or crinkled like cigarette paper, and small telangiectases were apparent. The size of the scars and pseudotumors and their hyperextensibility are illustrated in figures 1, 2 and 3. Nonpedunculated similar large scars were noted over the abdomen at the site of appendectomy, the anterior tibial areas, and the left arm at the site of smallpox vaccination. Additional scars were located over the forehead, nose, hands, forearms and left calf. The infected laceration on the right leg measured about 3 cm. in length. There were moderate traumatic deformities of the metacarpophalangeal joints of both thumbs. Hyperextensibility was present in the joints of the distal phalanges of both thumbs and of the middle three toes, bilaterally. A hammer toe deformity was present in these toes, with contractions and shortening of the skin overlying the proximal phalanges.

Urinalysis, complete blood counts, platelet counts, and bleeding and clotting times were all normal. The nonprotein nitrogen, fasting blood sugar, and serum phosphorus were also within normal limits. A roentgenogram of the chest showed only an irregularity of the diaphragm on the right side, presumably the residual of old pleurisy. Roentgenograms of the hands and spine also gave normal



Fig. 3. — Photograph showing hyperextensibility of pseudotumor of the right knee.

results. Hemolytic streptococci were cultured from the site of the laceration.

Histopathologic examination of skin from the right thigh showed an apparent increase in numbers of elastic fibers when the specimen was stained with Verhoeff's stain for elastic tissue and compared with a microscopic section or control preparation of normal skin.

Discussion

The case reported here presented only moderate but definite changes of the skin and of a few toe joints, as compared with descriptions in other reports and in a case observed by me previously. The patient was not aware of features of this syndrome being present in other members of his family; however, his fragile, thin skin had been commented on since childhood. Although subcutaneous nodules were not demonstrated in this case, all of the other cardinal signs were present in a modified form.

After one has observed a patient with Ehlers-Danlos syndrome, it is not difficult to recognize the syndrome or its formes frustes. In normal persons the feel of the skin of the eyelids and frequently the skin along the inner aspects of the arms somewhat resembles that of the skin in patients with Ehlers-Danlos syndrome; however, the abnormal rubbery feeling and hyperelasticity are absent. Also, in normal persons, large scars produced over the knees or elbows often have a wrinkled, papyraceous appearance similar to that of the scars of this syndrome. Pseudotumors of varying sizes, present in the scarred areas, are, however, distinctly characteristic of the Ehlers-Danlos changes. Although a history of similar conditions in members of the patient's family is helpful in diagnosis, sporadic cases of the complete syndrome have been reported.

As emphasized before, changes may be limited to certain areas of the body, and some of the cardinal signs of the syndrome may be missing. Findings on palpation of the skin as described and fragility of the skin are most suggestive in diagnosis. Changes in the joints without changes in the skin are unlikely. Since reports of findings in this condition as a result of biopsy of the skin vary widely, and since involvement may be limited as to degree or area, information gained from microscopic sections of tissue may be of questionable value, in some cases.

This condition is coming to be recognized more often in all fields of medicine, especially the formes frustes types. In the past year, I have seen 2 other military cases, in which there were only changes in the skin with minimal fragility. Several years ago I saw a civilian patient with pronounced changes in the skin and joints, but without pseudotumors. Her brother had similar involvement of the skin, but this was of a lesser degree; his joints were normal.

Summary

The Ehlers-Danlos syndrome is an unusual clinical condition manifested by (1) hyperelasticity of the skin; (2) fragility of the skin and blood vessels; (3) pseudotumors over bony prominences related to fragility of the skin and trauma; (4) hyperlaxity of the joints; and (5) movable, subcutaneous, fibrocalcific nodules.

The condition is variable, and some of the cardinal signs may be minimal or absent (formes frustes).

The etiology is unknown. It may be familial or sporadic. It is transmitted by a Mendelian dominant inheritance pattern in some cases.

Reports of biopsies of the skin describe a wide variation in histopathologic findings as regards the elastic and collagenous fibrils. Elastic fibrils are usually increased.

Treatment consists of measures to protect the skin from trauma; supports to joints, if necessary; special care in suturing lacerations; and pressure bandages to contusions to prevent formation of pseudotumors.

A case in a military patient is reported.

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ABSTRACTS

Granulosa Cell Carcinoma of the Ovary: Clinical and Pathological Review of Seventeen Patients. By Howard C. Duckett, M.D., C. D. Davis, M.D., and B. F. Fetter, M.D. Obst. & Gynec. 2:611-618 (Dec.) 1953.

A series of 17 cases of granulosa cell carcinoma of the ovary, observed in the Gynecological Clinic at Duke Hospital over a period of 17 years, is reviewed and analyzed. The discussion covers age, race, symptoms, abnormalities of uterine bleeding, pathology, associated pathology, malignancy, treatment and results.

In summary, it was concluded that the degree of malignancy in granulosa cell carcinoma is less than that in ovarian carcinoma generally. Five, or 29.4 per cent, of the patients in the series succumbed to carcinomatosis. The incidence is the same for women in the premenopausal and postmenopausal period and more common after the age of 40 years. This type of carcinoma is rarely encountered in childhood. There is no racial preference. Nine of the patients in the cases studied were white and 8 were Negro. Abnormalities of uterine bleeding are the characteristic manifestations of estrogenic activity. The degree of malignancy cannot be determined from the cytologic and histologic patterns. Evisceration of the pelvic genital tract is the treatment of choice, except in younger patients for whom unilateral oophorectomy may be chosen.

Sickle-Cell Anemia Complicated by Pregnancy: A Review of the Literature and Six Case Reports. By H. C. Duckett, M.D., and C. D. Davis, M.D. Am. J. Obst. & Gynec. 66:409-414 (Aug.) 1953.

Sickle cell anemia, a hereditary disease occurring only in the Negro race, is a chronic hemolytic anemia. To the 77 cases of sickle cell anemia complicated by gestation which they found in a review of the literature, the authors add 6 cases, which they describe. In the 83 cases there were 176 reported gestations and 100 successful pregnancies. In their 6 cases the patients experienced 19 pregnancies, in 10 of which some antepartum care was received at Duke Hospital.

In this series of 83 reported and collected cases only 56.8 per cent of the fetuses survived. The complications reported in the 176 pregnancies included infection of the urinary tract in 25, toxemia of pregnancy in 23, morbid puerperium in 21, pneumonia in 14, infection of the upper part of the respiratory tract in 8, thrombosis of the vascular system in 9, and infection of other types in 14. The maternal mortality was 22.8 per cent.

The conclusions were: All Negro obstetric patients who are severely anemic should be investigated for sickle cell anemia. The prognosis for the fetus is poor. Severe infections are common, and the incidence of toxemia is considerably increased. The maternal risk is grave.

Localization of Sites of Dehydrogenase Activity in the Cervix Uteri: Normal, Metaplastic and Neoplastic Epithelium and Cervicitis. By Alvan G. Foraker, M.D., Sam Wesley Denham, M.D., and Polinestor Aguilar Celi, M.D. Cancer 7:311-317 (March) 1954.

The study described in this report was undertaken to determine the sites and distribution of dehydrogenase activity in the cervix with relationship to growth as seen in metaplasia and in carcinoma, and under stimulus of inflammation. The material utilized consisted of tissue from 37 cervixes removed primarily for noncervical disease and carcinomatous tissue from 15 cervixes. Evidence of dehydrogenase activity correlated closely with sites of growth in both normal and abnormal epithelium as seen in this series. No qualitative or quantitative difference in manifestation of enzyme activity was found in neoplastic (invasive or noninvasive) epithelium, actively metaplastic epithelium, or the basal layer of normally maturing portio vaginalis epithelium.

Phenylephrine Hydrochloride in Paroxysmal Supraventricular Tachycardia. By Lieut. Commander Charles K. Donegan and

Lieut. Charles V. Townsend, (MC), U. S. N. R. J. A. M. A. 157:716-718 (Feb. 26) 1955.

A case is reported in which a patient with paroxysmal supraventricular tachycardia was treated effectively with phenylephrine (Neo-Synephrine) hydrochloride after therapy with quinidine, digitalis, apomorphine, ipecac, and procaine amide (Pronestyl) hydrochloride had been ineffective. The drug stopped the arrhythmia, but produced short runs of ventricular tachycardia. The authors found that the same phenomenon had been recorded in the literature, but that no particular emphasis or attention had been given it. Since it is universally accepted that ventricular tachycardia, even in short runs, is potentially of serious consequence, they concluded that this complication deserves additional attention and that phenylephrine must be used with caution as a potentially dangerous agent in the treatment of paroxysmal supraventricular tachycardia.

History of Medical Hypnosis. By Walter W. Sackett Jr., M.D. South M. J. 48:306 (March) 1955.

In his chairman's address before the Section on General Practice, Symposium on Medical Hypnosis, at the St. Louis meeting of the Southern Medical Association last November, Dr. Sackett traced the history of hypnosis from Mesmer's theory of animal magnetism of two centuries ago to hypnosis of the present day. Interest in the phenomenon persisted during the nineteenth century, particularly in France. With the advent of psychoanalysis interest in hypnosis declined, but was renewed with the First World War because of its application in the treatment of shell shock. Since then a gradual reawakening of interest in this subject has taken place in the various fields of medicine. In retrospect, this author concludes, it is clear that Mesmer introduced a medical tool which has been gradually shaped and welded into what may hold untold possibilities for the future.

A New Diagnostic Procedure for Cancer of the Larynx Using a Retractable Throat Brush. By J. Ernest Ayre, M.D. J. A. M. A. 156:770-771 (Oct. 23) 1954.

The recent introduction of brush cytology into the field of gastric cancer diagnosis has stimulated the development of new methods that may permit the application of brush cytology to previously inaccessible tissues. The retractable throat brush (Ayre) described in this article is designed in such a way as to enable the rapid brushing of the vocal cords by a retractable brush that rotates through 360 degrees and so collects a rich concentration of cells and secretion for cytologic examination as a means of diagnosing benign and malignant growths. Malignant cell brushings, however, should be confirmed by histologic study prior to therapy. While local anesthesia of the throat may at times be indicated, the brush procedure is so rapid that the irritation resulting from its use is of short duration and it is well tolerated without anesthesia. In a test series of 142 cases in which the throat cytology was studied, cell brushings gave evidence of malignant disease in 16, and in 9 cases the results were classed as "suspicious." Histologic follow-up examination in 14 cases confirmed the positive findings in 10, and also in 2 of the suspicious cases.

The need for a screening method for early cancer of the throat has been emphasized by recent publicity on the importance of ruling out malignant disease in heavy smokers suffering from throat irritation. It is suggested that a simple technic such as that described here may play a useful role in annual cancer examinations and in examination of patients suffering prolonged hoarseness or throat irritation.

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Physicians and Medicine in Early Alachua County and Gainesville, Florida

Part II
War and Pestilence

Two events of 1835 left deep scars in their wake and made that year memorable. The worst freeze recorded in the history of Florida occurred on February 8 and 9, and the Seminole Indians massacred Major Francis Dade on December 28. The freeze killed virtually all the orange trees in the state and temporarily paralyzed business activity; the temperature dropped to 8 degrees above zero and remained below freezing for two days. Dade's massacre marked the onset of the Seminole War, which lasted more than six years, caused the death of many men, and brought further paralysis of commercial activity throughout a large part of the state.

In that eventful year Dr. George Morton Payne* arrived at Micanopy to begin the practice of medicine.[1] Following sharp skirmishes with Indians, the fort at Micanopy was abandoned during the summer of 1836,[2] and a military post was not established there until April 1837,[3] while the Post Office was discontinued in the fall of 1837 not to be re-established until 1842.[4] At times the little town was virtually deserted. It is not known how Dr. Payne was able to carry out his duties as a physician during those harassing years. Army surgeons shared his labors for a time during their service with army posts in the region, but with movement of their troops they were transferred, leaving him alone to serve the sick in the whole region.

Many orange growers between Jacksonville and Fort King, later Ocala, became discouraged by the devastating effect of the severe freeze and turned to other occupations, but not Dr. Payne. He apparently was among the first in the central portion of the state to recognize the advantages of raising sweet oranges rather than the bitter-sweet. He obtained seed from selected china fruit, planted them on the old Crosby place, later the location of Mrs. George Shuford's home, grew several trees, and began to distribute the fruit throughout the territory he served. As a result good seedling groves sprang up everywhere. At that time sweet seedling fruit was recognized as being an uncertain crop, but the trees from the

*Not to be confused with his son, Dr. George Booker Payne, who came to Micanopy in the late 1840s and lived there until his death in 1859. Dr. George B. Payne had two half brothers, Drs. John and Nettleton Payne, who lived and practiced medicine near Orange Lake before the War Between the States.[5]

seed of Dr. Payne's fruit apparently bore regularly and at an earlier age than most sweet seedling trees. His pioneering adventures with this new fruit have been credited as furnishing the revival of the orange industry in the region extending from Alligator, now Lake City, on the north to Lake Weir on the south.

During the period just preceding the Seminole War, plantations in central Florida became more numerous, cotton was planted more extensively, and the planters and wealthier class became more prosperous. The little farmers and so-called squatters, however, did not make out so well. They lived in crude huts with dirt floors, simple windows and mud chimneys. Their fare is said to have consisted chiefly of "corn pone, clabber, dried beef, venison and wild honey. Sometimes they had salt pork and coffee."[6]

The northern part of Alachua County developed during that period at a faster pace than the southern. The site of the county seat, which had been established at Newnansville in 1828, had been changed to the "House of Edward Dixon" in 1832 when creation of Columbia County from Alachua County placed Newnansville in the new county. In 1839, however, by adjustment of county boundary lines, Newnansville was placed in the extreme northeastern portion of Alachua County and re-established as the county seat.

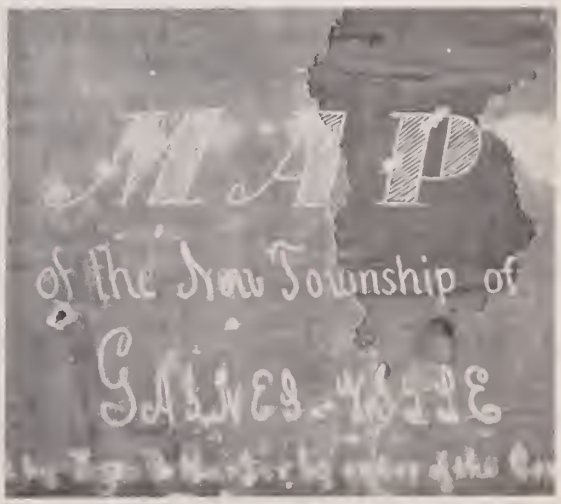
Recovery following the Seminole War came quickly. From 1842 until the outbreak of the War Between the States, Florida grew rapidly. Under the Armed Occupation Act of August 4, 1842, the Federal Land Office granted "a quarter section of land to heads of families and single men over eighteen years of age, able to bear arms, who should, within one year of the passage of the Act, make an actual settlement in the part of Florida lying south of a line from Palatka through a point about 10 miles south of Newnansville."[7] This inducement appeared to start a shift of population density from northern toward middle and southern Alachua County.

Gainesville Founded

During the early 1850s, plans for the Florida Railroad, which was to be built from Fernandina to Cedar Key, showed that it would miss Newnansville and would pass through the central part of the county near the Hog Town district. By 1852 residents in that area were making plans for a new town, which they hoped would become the county seat as well as a center for trade and commerce.[8] Those citizens doubtless were responsible for an act passed by the state legislature that year which provided for a county-wide vote whereby the people might select a new county seat.[9] Apparently as a result of that act, all citizens of the county were invited to a barbecue and picnic at Boulware Springs, just east of the site of the Gainesville water works today, to settle by vote the question of the site of the county seat and a name for the new town. A contest is supposed to have developed between those who wanted the town named Gainesville for General Edmund P. Gaines of Seminole War fame and those who wanted to name it Lewisville for a prominent planter in the Hog Town district. Major James B. Bailey, an early settler in the central portion of the county, is said to have won the day by proposing that if they gained the courthouse for the new little town, it would be named Gainesville, and if they lost the courthouse, the town would be named Lewisville.[10]

Many years later, Mr. James Doig, an early settler, wrote that the town was not named for General Gaines, but was named Gainsville at the suggestion of Major Bailey because the eastern part of the county had gained the vote in the election.[11] This view seems to have been supported by the fact that from the time of the recording of the new town as the county seat on September 6, 1854, in the minutes of the county commissioners until December 12, 1859, the name was consistently spelled without the e, Gainsville.[12]

The first map of the town, however, carries the legend:



Surveyed by Jesse B. Hunter by order of the Commissioners September 17th, 1853.

Likewise, when the United States Post Office was established at the new little town on July 5, 1856, its name also was spelled with the e, Gainesville.[13] There can be little doubt that Gainesville



Fig. 1.— Dr. William H. Stringfellow.

was named for General Edmund Pendleton Gaines and that the spelling of its name has not been changed since the date of its founding.

Often it is difficult to say exactly when a town was born or began to exist. By general acclaim 1954 was appointed as the centennial year for the celebration of Gainesville's founding. Although there was not enough of a village there in 1855 to serve as a stopping point for a stagecoach which traversed that area between Micanopy and Newnansville and it was not large enough to be designated as a location for a United States Post Office until 1856, still efforts toward its founding had been begun several years before and that year, 1854, seems appropriate. The excellent cooperation given by Gainesville's citizens during the centennial year under the leadership of the Gainesville Sun has resulted in preservation of valuable little-known material which otherwise might have been lost. During that year, Charles H. Hildreth finished assembling his Gainesville historical material, a labor of love, in partial fulfillment of the requirements for a Ph.D. degree at the University of Florida. That scholarly history, a mimeographed copy of which is preserved at the P. K. Yonge Library of Florida History, will be a "must" for all who wish to study Gainesville's history during the first hundred years of the city's existence.

Land for the proposed town, some 100 acres, was bought from Major Bailey and the estate of Dr. Nehemiah Brush for less than $650.[14] The courthouse, completed in 1856, became the center of the town. Property around the courthouse square brought the highest prices and was most in demand. The entire block on South Main Street from University Avenue to Southwest First Avenue sold for $190.[15] Gradually stores, shops and hotels were built around this square.

Early Alachua County Physicians

During Gainesville's earliest years, three able young physicians, Drs. McCaa, Stringfellow and Thomas, chose the town for their homes and began the practice of medicine there. Dr. Gabriel Phillip Thomas, born in South Carolina on September 8, 1827, appears to have arrived in 1855 and to have settled near the center of the town. On October 10, 1856, he received title to the plot now occupied by Sears, Roebuck and Company at 14 South Main Street, and later he built a home on North Main Street. Father of Major W. R. Thomas and Dr. T. F. Thomas, two of Gainesville's best known citizens, Dr. Thomas lived in the little town and served the community for some 35 years until his death on August 8, 1890.[16]



Fig. 2.— Dr. Thomas Whitaker McCaa.

Dr. William H. Stringfellow[60] (fig. 1), born in South Carolina in 1818, arrived in Alachua County in 1856 and settled just west of Gainesville on the Newberry road at Fort Clarke, on what was later known as the Stringfellow plantation. He rode horseback for many miles to attend the sick. Also, he became interested in civic progress and the welfare of his community, induced the Reverend W. J. McCormick to locate in that section, and was largely responsible for the building of a Presbyterian church near Arredondo station and for the founding of the First Presbyterian Church in Gainesville. This pioneer physician was the father of three well known Gainesville residents, J. D. Stringfellow, T. B. Stringfellow and Mrs. Sallie R. Walker. Unfortunately, Dr. Stringfellow's health failed prematurely, and he was not able to be very active in his profession during the War Between the States and the reconstruction era. He died in Aiken and was buried in Union, S. C., in 1869.

Dr. Thomas Whitaker McCaa[61] (fig. 2), also a South Carolinian, was born on April 20, 1828. He settled beyond Sweetwater Branch, east of Gainesville, and appears to have become the best known and busiest physician of the territory during the early postwar era. At the height of his career he died of yellow fever in Gainesville on September 25, 1871, having contracted the disease in a neighboring town where he was called to attend patients suffering in an epidemic.

Gainesville was still a very small town in the late 1850s,[17] but it was beginning to show signs of substantial growth as was the county as a whole, which had a population of a little more than 8,000 in 1860.[18] The War Between the States, however, changed the whole outlook. Gainesville's citizens, eastside, westside and in the center of town, who had enjoyed unusually good medical attention for that day, soon apparently had no physician at all, then only one. Fortunately, however, there was no widespread or serious sickness during the war. In later years Dr. E. G. Clay of Fernandina wrote:

> I practiced in Gainesville and vicinity . . . from the summer of 1862 to fall of 1865. . . . I looked upon that whole country as exceedingly healthy, and what sickness there was, was of a mild type and generally very easily managed.[19]

One of several Alachua County physicians known to have had considerable active duty during the War Between the States was Dr. James Alexander Williams (fig. 3). Born in Charleston, S. C., on October 23, 1836, and graduated by Savannah Medical College in 1855, he had settled in Newnansville in 1856. Interested in surgery, he is said to have amputated the leg of a soldier without anesthesia following the Battle of Olustee.[20] In the book, Dickison and His Men, he is identified in a description of "The Battle of Gainesville" (fig. 4) as Captain Dickison's "noble surgeon . . . as brave a soldier as ever followed a leader into battle. . . ."[21] A successful planter and fruit grower as well as a physician,[22] he lived in Newnansville until his death on November 28, 1895.[23]



Fig. 3. — Dr. James Alexander Williams.

Another prominent young physician of Alachua County who played an unusually active part in the war was Dr. John Crews Pelot. Dr. Pelot, a member of the Florida legislature during its well know secession convention, volunteered his services from Alachua County as a private in 1862, but was soon made an assistant surgeon.[24] He had the unique experience of being physician and surgeon to the Andersonville, Georgia, Prison Hospital after its establishment in 1863. His manuscript articles describing his duty at "Floyd House Hospital and Andersonville Prison Hospital" have been preserved by Mr. John J. Pelot of Manatee, Fla.[25]

Postwar Progress

The New Era, a weekly newspaper, volume 1, number 1 of which was published in Gainesville on July 8, 1865, carried this message:

(Continued on page 304)

Quiz
for
doctors

(you probably know every answer!)

Q. Which is today's most widely prescribed broad-spectrum antibiotic?

A. ACHROMYCIN — it's first by many thousands of prescriptions.

Q. What are some of the advantages of ACHROMYCIN?

A. Wide spectrum of effectiveness.
Rapid diffusion and penetration.
Negligible side effects.

Q. Exactly how broad is the spectrum of ACHROMYCIN?

A. It has proved effective against a wide variety of infections, caused by Gram-positive and Gram-negative bacteria, rickettsia, and certain viruses and protozoa.

Q. In what way are ACHROMYCIN Capsules advantageous?

A. For rapid and complete absorption they are dry-filled, sealed capsules (a Lederle exclusive!) No oils, no paste...tamperproof.

Q. Who makes ACHROMYCIN?

A. It is produced — every gram — under rigid quality control in Lederle's own laboratories and is available only under the Lederle label.

CHROMYCIN*

Hydrochloride
Tetracycline HCl Lederle

Lederle

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY PEARL RIVER, NEW YORK

*REG. U.S. PAT. OFF.



Fig. 4.—Battle at Gainesville, Florida, in 1864, as depicted in Dickison and His Men,[21] *p. 89.*

> The man who yields to the grim visage of despondency will not be prepared in the present emergency to act well his part in the coming drama of life. Try, then, to be cheerful; let us mingle again in the busy scenes as of old. . . .[26]

The following issue listed prices of articles in the Gainesville market with the statement that stocks were small, that money was scarce in proportion, and that country produce of all kinds found a more ready market than anything else. Selections from the list follow:[27]

Ale, per bottle, $1.00
Beef, per pound, 12½¢
Butter, per pound, 25¢
Coffee, per pound, 75¢
Eggs, per doz., 10¢
Lard, per pound, 15¢
Castor Oil, per quart, $2.50
Quinine, per oz., $7.50
Sulpher, per pound, 50¢
Saltpetre, per pound, $1.00

Soon Gainesville was making excellent progress commercially and business was actually booming. A note in the New Era during the fall of 1865 stated that the town was far ahead of other interior towns in the state in regard to trade.[28] The next spring the paper declared that Gainesville would be the controlling market for Alachua and Marion counties,[29] and in the spring of 1867 an article reported that no town in Florida had made more rapid progress following the war, that buildings were springing up like mushrooms and that new stores lined the streets.[30]

Yellow Fever

In 1871, the Florida Gazetteer stated that Gainesville was noted for its general good health; that hotels in course of erection were destined to be well patronized by invalids and pleasure seekers.[31] Until that time there had been relatively little illness. Smallpox had appeared in a nearby gulf coast town during the spring of 1866 and spread to Gainesville, but only a few cases occurred.[32] There had been a cholera scare at Jacksonville and Cedar Key during the fall of the same year,[33] and during the summer of 1867 an increased incidence of undiagnosed fever in Gainesville had made authorities fear an epidemic of yellow fever and order a general clean-up campaign.[34] The first epidemic of real proportions, however, occurred during the fall of the year 1871 and dealt the growing town a devastating blow.

The summer of that year was hot and wet. Rains were reported as continuous and copious.[35] The first case which resembled yellow fever appeared in Cedar Key on August 20, and the first death occurred there about September 1. At that time the little town, located on the Gulf of Mexico some 60 miles southwest of Gainesville, had a population of approximately 350, half of whom were white people. Cedar Key was recognized as being vulnerable to "contagious diseases" because

of the ships which docked there en route from Havana and Key West to New Orleans and because of the railroad which brought passengers from Fernandina and Jacksonville. In Cedar Key, however, as in other towns of the South during that period, facts concerning a suspected epidemic were concealed, for many held that it was better to suppress the truth than produce a panic. On Sunday, September 10, when six deaths occurred during that day and the night before, panic was of course the inevitable result. During the intense excitement everyone who was able to get away left promptly.[36]

Mr. L. F. Roux and Col. M. W. Downey, two sick refugees from Cedar Key, appear to have carried the fever to Gainesville. The first illness of this nature among the citizens there was that of a Mr. Dozier.[37]

A newspaper dated September 16 admitted that there had been four or five sudden deaths in Gainesville, but claimed that the town was still blessed with good health — that while their neighbors were suffering with disease and death and some were fleeing from their homes, Gainesville's citizens were enjoying the blessings of home and health.[38] At about that time, Dr. McCaa, who had been called to Cedar Key to attend the sick, became ill, returned to Gainesville, and despite the efforts of his physician friends, died on September 21.[39] The inscription on his gravestone reads:

Dr. Thomas W. McCaa
God's noblest work
An honest man.

Toward the end of September the epidemic began to die out in Cedar Key and in early October came to an end. An article in the Jacksonville Union, dated October 3, stated that only approximately 12 people were left at Cedar Key; that the railroad workmen were being kept at Otter Creek, 14 miles distant, and were being transported back and forth daily after sunup and before sundown.[40]

There seems to have been a blackout of news from Gainesville from late September until early November, when a correspondent from Gainesville was quoted in a Jacksonville paper as saying there was a malignant type of fever there which certainly resembled yellow fever and which in most cases was proving fatal.[41] Another letter from Gainesville, dated November 13, was quoted by a Savannah paper as saying that there were 40 cases of yellow fever in the little town and that there had been many deaths.[42] The New Era of Gainesville, dated November 11, stated there had been nine deaths that week.[43] Further information from Gainesville published in Jacksonville on November 16 admitted seven more deaths after November 12,[44] and the New Era published November 25 admitted that the fever was still afflicting Gainesville's citizens, that there had been more deaths, and that the epidemic had been "very fatal."[45]

On December 2, the New Era reported that the fever which had "swept off" so many of Gainesville's best citizens had materially abated because of cool weather[46] and on December 16 announced that several frosts and a good freeze having occurred, the few citizens who were still absent could return without further fear of "the late fatal fever."[47]

A total of 50 deaths are reported to have occurred,[48] a number which is startling when one considers the small population of Gainesville at that time. Apparently the mortality rate, and the total number of deaths as well, greatly exceeded those of the much better known yellow fever epidemic which occurred 17 years later, in 1888. Actually, this epidemic of 1871 has been almost entirely forgotten. It is still referred to by a few old Gainesville residents as the first epidemic to distinguish it from the second, but its date has been variously given as 1872,[49] 1876,[50] 1877,[51] and 1878.[52]

It was during this disastrous epidemic that



Fig. 5.—Dr. James F. McKinstry

local citizens observed that those who left town to sleep each night and returned during the mid-portion of each day were apt to escape the contagion and that among those who returned to the town and remained there one or more nights, there was a higher incidence of illness.

Postwar Physicians

During the year 1871 five physicians, besides Dr. McCaa who died in September of that year, practiced in Gainesville.[53] Of these, Dr. R. Y. H. Thomas, who practiced with his brother, Dr. G. P. Thomas, stayed only a short time before moving to another locality in Florida. Dr. George A. Penny and Dr. J. H. Verdier, not very well known, did not stay long. Fortunately, however, Dr. James F. McKinstry (fig. 5), 14 years younger than Dr. McCaa, became a life-long resident and outstanding citizen as well as an able physician and worthy successor to Dr. McCaa.

Born in Winnsboro, near Columbia, S. C., on December 17, 1842, Dr. McKinstry moved to Alachua County with his parents when he was hardly four and settled near Newnan's Lake. He served during the War Between the States, was graduated by the Long Island Medical College in 1866 and on September 12 of that same year was married to Miss Isabelle McCall, the daughter of Stephen McCall, one of Gainesville's pioneer residents.[54]

In early 1867, Dr. McKinstry practiced for a short time as an associate of Dr. G. P. Thomas.[55] In May of that year he announced that he had a building on the town square for rent, suitable for an office.[56] That office apparently is the same as the one he occupied in 1872 on Liberty Street, now University Avenue, near East Main Street, North, now Northeast First Street, shown in figure 6.

Affectionately known as Dr. Jim to distinguish him from his son, who was known as young Dr. Jim,[57] Dr. McKinstry served his town and region with distinction during the yellow fever epidemic of 1888.[58] He practiced with young Dr. Jim for many years in an office on North Main Street across from the old Atlantic Coast Line Railroad station.

After he had been appointed Postmaster at Gainesville in 1915, he announced his retirement as a practicing physician with these words:

> I sever the old relations with profoundest regrets; but I speak no goodbye, for the heart like the mind, hath its own memories and enshrined there I shall carry [these memories] with me into the Beyond.

Active in mind and spirit until the end, he was working among his flowers in his garden on the day of his death in 1926.[59]



Fig. 6. — Gainesville about 1872. Buildings on the north side of the Square on what is now University Avenue between Main and Northeast First streets. From left to right: 1. Shoe store of J. D. Matheson. 2. Office of Dr. J. F. McKinstry with Dr. McKinstry standing in the doorway. 3. Post Office. 4. Drugstore of R. C. McCall, later sold to Dr. A. J. Vidal. Upstairs was located in 1876 the office of the Gainesville Times, predecessor of the Gainesville Daily Sun, where articles were written, type was set, and the paper was printed, all by hand.

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Practical Program of Public Relations Five Major Aspects

IV. Working With Others

Patients are people. The physician who thinks of them as numbers or cases or examples of some particular disease is out of tune with modern medicine. As mentioned last month in the third of this series of editorials on the practical public relations program of the Florida Medical Association, the doctor specializes primarily in people. The very nature of his profession requires him to make a business of people. Fortunately, the science of medicine and the art of medicine are so happily wedded today that the physician views his patient in the light of the total personality. He keeps his attention focused on the patient, not merely as the site of a disease, but as a human being, a member of a family and a community, beset with many problems, other than his immediate illness, which require advice and adjustment.

"The doctor is the friend, counselor and advisor to the family to whom he administers care," said Vice President Alben W. Barkley, addressing the Aero Medical Association in 1952. "I would rather have one country doctor working for me politically among my friends than anyone else. Doctors justify their profession and the confidence people give them."[1] Unquestionably, the practice of medicine qualifies as a training school in public relations. In the school of everyday experience the physician learns how to get along with patients in particular and people in general. He works, for example, with the Woman's Auxiliary, allied organizations, other professional groups, civic organizations and sponsors of community projects, organized labor, and state and independent agencies. These six groups form the basis of the Association's public relations program of working with others.

The Woman's Auxiliary is a most valuable asset to the public relations program. The activities of this energetic and enthusiastic group have been incorporated more and more into the local public relations pattern, and the Auxiliary members have rendered yoeman's service in carrying out many a project. They are peculiarly fitted and strategically situated to perform effectively their role in medical public relations. The Association salutes them.

61. Letters from Mrs. Esther B. Jordan, Gainesville, Fla., and Mr. J. McCaa Haile, Jacksonville, Fla.; Matheson;[39] and interview with Mrs. A. E. Barker, Jacksonville, Fla.

Liaison and cooperation with allied groups constitute a particularly important aspect of the public relations program. These groups include dentists, druggists, nurses, medical assistants, medical technicians and others. Merely to enumerate them indicates the value of smooth working relations, which thrive in an atmosphere of harmony and understanding, and seek always to obtain the primary objective of the best medical care for the patient. A cheerful, considerate attitude on the part of the physician rarely fails to guarantee reciprocal cooperation from those who are as necessary to the physician in the practice of his profession as he is to them in the practice of their professions.

Likewise, liaison and cooperation with other professional groups, notably ministers and attorneys, make a most worthy public relations objective of physicians in this day of emphasis on the psychosomatic concept of medicine. If the total personality of the patient is to be served, as modern practice dictates, members of these other professional groups are not infrequently in a position to render invaluable aid. It is noteworthy, too, that in recent years liaison between the medical profession and, for example, the legal profession, as well as the allied professions of pharmacy and dentistry, has become closer, having received much stimulus through recognition of the threat of socialization and effort to stem the tide of this evil, whose proponents chose as their first target the practitioners of medicine. The guardians of the nation's health have found welcome support from other professional groups, which should be fostered and promoted continually in a never ending effort to keep the guard up against this threat that has by no mean ended.

The active participation by the physician in civic organizations and community projects pay big public relations dividends. In his role of Mr. Public Relations himself, mentioned in the preceding editorial of this series, the doctor has countless opportunities to inform the public of medicine's lofty ideals, worthy objectives and practical aspects, as well as to shape public opinion so that medicine's magnificent accomplishments, looking to the best medical care for all the people, will have fuller appreciation. While individually and in the aggregate the doctor is public relations, so to speak, he receives as well as gives. Student that he is, individualist that he prides himself on being, too long inclined to remain aloof, he is debtor to his relatively new role in public relations for contact and experiences beyond the scope of the immediate doctor-patient and personal social relationships, which have a broadening, seasoning, balancing influence that is inevitably reflected in his professional proficiency.

An advisory and liaison relationship with organized labor is a facet of public relations which promises much and merits assiduous cultivation. Amicable relations with labor organizations provide abundant opportunity for explaining the policies of the medical profession and its stand for free enterprise and health services on a voluntary basis. Understanding, in turn, will go far toward promoting full cooperation. Also, physicians engaged in the practice of industrial medicine have a unique opportunity to be special public relations emissaries.

Naturally, coordination and planning with state and independent agencies to maintain high health standards for the people of the state is a public relations duty which becomes a privilege. The rapport between the Association and the Florida State Board of Health, under the able leadership of Dr. Wilson T. Sowder, State Health Officer, is a notable example of rewarding public relations. Another is the Committee on Indigent Hospitalization, appointed by Governor Collins at the request of the Association. The efforts of this committee culminated in passage of a law at the recent session of the legislature which establishes state funds to match county funds for hospitalization of acutely ill indigent persons. Many instances of cooperation with independent agencies also might be cited.

The Association's practical program of public relations is in keeping with the positive program throughout the United States. That program has been a feature of the nation's medical progress which has given this country the world's highest standards of health and medical care. This progress has been achieved under a voluntary system which emphasizes free enterprise, individual initiative and responsibility, and cooperative effort. It has been accomplished by physicians, but not by them alone, for they have had the help and cooperation of the groups mentioned and, in addition, of many branches of science, hospitals, business, industry, education and all segments of American society. To medical public relations in Florida and throughout the nation falls the pleasant task of promoting this cooperative endeavor so that new heights may be scaled in the quest for the best medical care for all the people.

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Medical District Meetings October 10-14, 1955

The programs for the four Medical District Meetings have been announced by Dr. Ralph W. Jack of Miami, chairman of the Council of the Florida Medical Association, which sponsors the series of meetings. Arranged with the assistance of the eight district councilors, the programs are scheduled for October 10, 11, 12 and 14 at Fort Lauderdale, Lakeland, Gainesville and Pensacola respectively.

In charge of arrangements for the 16th annual meetings are the district councilors: Southeast District, Drs. Ralph S. Sappenfield, Miami, and James R. Sory, West Palm Beach; Southwest District, Drs. Coy L. Lay, Lakeland, assisting Councilor James R. Boulware Jr., Lakeland, and C. Frank Chunn, Tampa; Northeast District, Drs. Henry J. Babers Jr., Gainesville, and Charles L. Park Sr., Sanford, and Northwest District, Drs. William P. Hixon, Pensacola, and Walter J. Baker, Foley.

The general subjects for each of the four meetings are jaundice and blood. Scientific papers on various phases of the subjects are to be presented. However, the programs have been designed to be sufficiently diversified in order that the interest of general practitioner and specialist may be served.

Guest speakers for each of the four meetings are Dr. George T. Harrell Jr., Gainesville, dean, College of Medicine, University of Florida, and Dr. James J. Griffitts, Miami, president-elect, American Association of Blood Banks, and associate director of the John Elliott Blood Bank of Dade County.

Dr. Homer F. Marsh, Miami, University of Miami, School of Medicine, will also speak briefly at each meeting.

Following the precedence set by past Medical District Meetings, officers of the Association are to present brief addresses following the scientific program of each meeting. Officers scheduled to speak are Drs. John D. Milton, of Miami, President; Francis H. Langley, St. Petersburg, President-Elect; Samuel M. Day, Jacksonville, Secretary-Treasurer, and Shaler Richardson, Jacksonville, Editor of The Journal of the Florida Medical Association.

The meeting in Fort Lauderdale is scheduled to begin at 2:00 p.m. At 6:00 refreshments will be served followed by dinner at 7:30. The meetings at Lakeland and Gainesville follow this time schedule, while the one at Pensacola will begin one hour later, at 3:00 p.m., Central Standard Time, with refreshments being served at 6:30 followed by dinner at 8:00. Printed programs will be mailed to all members of the Association prior to the meetings.

The annual Workshops of the Woman's Auxiliary are to be held in connection with each Medical District Meeting. Each doctor's wife is urged to attend these informal sessions. Mrs. Samuel S. Lombardo, Jacksonville, president of the Auxiliary, has announced that the ladies in the Southeast District are to meet in the home of Mrs. Francis D. Pierce, 509 Isle of Palms, Fort Lauderdale, on October 10 at 2:00 p.m.; those in the Southwest District at the Lakeland Yacht Club on October 11 at 1:30 p.m.; those in the Northeast District in the Student Union Building, University of Florida, October 12 at 2:00 p.m., and those in the Northwest District in the San Carlos Hotel, Pensacola, October 14 at 3:00 p.m. Following the Workshop in each District, the ladies are to join their husbands for refreshments and dinner.

Scientific Assemblies — Four Medical Districts

Monday, Oct. 10 — 2:00 p.m.

Fort Lauderdale — D

Bahia Mar Club

Presiding: Ralph W. Jack, Chairman of the Council, and Ralph S. Sappenfield, of Miami, Councilor of District 8.

Address of Welcome, Ernest E. Serrano, President, Broward County Medical Association.

"Medical Aspects of Jaundice," George T. Harrell Jr., Gainesville.

"Surgical Aspects of Jaundice," Charles L. Wadsworth, Fort Lauderdale.

"Problems in Use of Blood and Blood Substitutes," James J. Griffitts, Miami, and John H. Mickley, Hollywood.

Tuesday, Oct. 11 — 2:00 p.m.

Lakeland — C

Lakeland Yacht Club

Presiding: Ralph W. Jack and James R. Boulware Jr., of Lakeland, Councilor of District 6.

Address of Welcome, Samuel J. Clark, President, Polk County Medical Association.

"Medical Aspects of Jaundice," George T. Harrell Jr., Gainesville.

"Surgical Aspects of Jaundice," Thomas E. McKell, Tampa.

"Problems in the Use of Blood and Blood Substitutes," James J. Griffitts, Miami, and Charles Catanzaro, Tampa.

Wednesday, Oct. 12 — 2:00 p.m.

Gainesville — B

Auditorium, Student Union Building, University of Florida

Presiding: Ralph W. Jack and Charles L. Park Sr., Sanford, Councilor of District 4.

Address of Welcome, Edwin H. Andrews, President, Alachua County Medical Society.

"Medical Aspects of Jaundice," George T. Harrell Jr., Gainesville.

"Surgical Aspects of Jaundice," Ashbel C. Williams, Jacksonville.

"Blood Transfusions," James J. Griffitts, Miami.

"Plasma and Plasma Expanders," Oscar W. Freeman, Orlando.

Friday, Oct. 14 — 3:00 p.m.

Pensacola — A

Pensacola Yacht Club

Presiding: Ralph W. Jack, and William P. Hixon, of Pensacola, Councilor of District 1, George T. Harrell Jr., moderator.

Address of Welcome. George W. Morse, President, Escambia County Medical Society.

"Surgical Aspects of Jaundice," Walter C. Payne Jr., Pensacola.

"Medical Aspects of Jaundice," George H. Garmany, Tallahassee.

James J. Griffitts, President-Elect, American Association of Blood Banks, Moderator.

"Blood Substitutes," Jack W. Fleming, Pensacola.

"Blood Transfusions and Reactions," Gerard H. Hilbert, Pensacola.

The Tumor Clinic and Cancer Registry

At the present time there are 19 tumor clinics in operation in Florida. These tumor clinics are operated by the local hospital staffs and have the approval of the county medical society concerned. Each clinic is financed by the American Cancer Society and the Florida State Board of Health. Space and other facilities are provided by the hospital concerned. All physicians that take part in the clinic donate their services.

The purpose of these clinics is to provide diagnostic services and treatment for those indigent cancer patients who offer a reasonably fair prognosis. The standards for the operation of the tumor clinic as recommended by the Florida Cancer Council and other agencies concerned are that the clinics meet the requirements of the American College of Surgeons.

A representative of the American College of Surgeons recently inspected 12 of the tumor clinics in Florida. He gave full approval of seven tumor clinics and provisional approval of five. No doubt the other seven tumor clinics will be inspected at a later date. The findings and recommendations of the inspecting officer have been submitted to each of the tumor clinics concerned.

The requirements of the College of Surgeons for the operation of the tumor clinics are being changed. On and after Dec. 31, 1955, each clinic should operate a Cancer Registry if it is to have the approval of the American College of Surgeons.

A manual for cancer programs, published by the American College of Surgeons, outlines the minimum requirements that should be met to get its approval. Copies of the manual are available either from the American College of Surgeons or from the Florida Cancer Council, Box 210, Jacksonville. Below are some of the requirements and purposes of the Cancer Registry as outlined in the manual:

"In general the purposes of the registry are as follows:

"1. To record from a specified date the name of every patient with cancer or suspected cancer admitted to the in- or outpatient services of the hospital, thus building a master file for the entire hospital cancer case load.

"2. To have available a file of medical record abstracts with the details of diagnosis, treatment and follow-up of each cancer patient for teaching, evaluating, research or reporting purposes, according to volume and facilities involved.

"3. To have a systematic means of establish-

ing regular follow-up of every cancer patient to keep him under adequate medical observation as long as he lives. Inherent in this objective is the addition of the follow-up information to the abstract of the patients.

"4. To have available the data on cancer for annual reports, or reports to the medical staff, or where the volume warrants it for more comprehensive statistical analysis.

"5. The minimum content required of each registry is the name and address of every patient, private and public, inpatient and outpatient, upon whom a diagnosis of cancer is or has been previously made, with adequate identifying and diagnostic information, with a basic abstract of the clinic record and an annual follow-up note for as long as the patient remains alive. From this base, the content may be elaborated as far as those conducting the registry desire.

"If at all possible, the registry should be assigned an office of its own physically available to the record office and the cancer clinical activities. In smaller hospitals the registry office activities may be conducted in direct association with the cancer clinical activities' office."

It is realized that if the Cancer Registry functions as it should, it will require the support of every physician on the hospital staff. It will mean that each of us should be more thorough in writing up our clinical histories, physical findings, operating procedures, and treatment rendered to patient. One of the main purposes of having a cancer registry is to make it possible for the staff members of the hospital to evaluate their own treatment procedures in comparison with other fellow staff members or in comparison with other treatment centers. The information kept in the Registry is considered of a confidential nature and should be made available only to the hospital staff concerned, according to the policies of the hospital. The Registry is intended to include private patients as well as charity patients. Through the Cancer Registry patients can be followed up and at the same time there need be no violation of the usual medical ethics. Through the Registry delinquent patients can be urged to return for further treatment if it is indicated and recommended by the attending physician.

It is believed that the American College of Surgeons should be commended in establishing the new regulations that have been recommended inasmuch as the Cancer Registry will provide each physician a means whereby he can evaluate his own services to the patient in comparison with those of his colleagues and thereby learn from his experience.

Plans are being made to have a meeting this fall of all of the tumor clinic directors, a representative of the American College of Surgeons, and representatives of the American Cancer Society and Florida Cancer Council, to offer detailed instructions on the operation, advantages and purposes of the Cancer Registry.

Hospitals in which tumor clinics are in operation are advised to make plans for the operation of a Cancer Registry if it has not already been done.

L. L. Parks, M. D.
Secretary, Florida Cancer Council

Graduate Medical Education
Diabetes Association
Daytona Beach, October 20-21

The third annual meeting of the Florida Clinical Diabetes Association will be held at the Princess Issena Hotel in Daytona Beach on October 20 and 21, 1955. The group is honored to have as its guest speaker for the dinner meeting on October 20 Dr. Otis L. Anderson, Assistant Surgeon General of the United States Public Health Service, who will give a "Progress Report on the Poliomyelitis Vaccine Program." Any physician desiring to attend this dinner may do so whether registered for the course or not. Advance reservations will be necessary and can be made at the registration desk in the Princess Issena Hotel.

The faculty consists of Dr. Joseph T. Beardwood Jr., Professor, Diseases of Metabolism, Graduate School, University of Pennsylvania; Director, Medical Services, Abington Memorial Hospital, Philadelphia, Pa.; Dr. Franklin Epstein, Assistant Professor of Medicine, Yale University School of Medicine, New Haven, Conn.; Dr. Fred Mathers, Orlando; Dr. George C. Austin, Miami; Dr. Samuel Wells, Jacksonville; and Dr. E. V. Anderson, Pensacola. The return of Dr. Beardwood to the program is most pleasing to the members of the Association. The subjects to be discussed by the faculty are varied and will be of interest to practically the entire medical profession.

The program of the Diabetes Association is being presented to precede immediately the annual meeting of the Academy of General Practice on

THIRD ANNUAL MEETING
FLORIDA CLINICAL DIABETES ASSOCIATION
PRINCESS ISSENA HOTEL, DAYTONA BEACH, OCTOBER 20-21

THURSDAY, OCTOBER 20 Moderator: Dr. Sidney Davidson, President

8:30- 9:00	Registration	
9:00- 9:15	Welcoming Remarks Dr. Robert L. Miller, President Volusia County Medical Society	
9:15-10:00	Diabetic Retinopathy	Dr. Beardwood
10:00-10:20	Diabetic Neuropathy	Dr. Mathers
10:20-10:30	Recess	
10:30-11:15	Clinical Correlates of the Kimmelstiel-Wilson Lesion	Dr. Epstein
11:15-11:35	Anesthesia for the Diabetic Patient	Dr. Austin
11:35-11:45	Recess	
11:45-12:30	The Surgical Diabetic Moderator: Dr. Joseph J. Lowenthal	Dr. Beardwood
2:00- 3:00	Fluid and Electrolytes in the Treatment of Diabetic Ketosis	Dr. Epstein
3:00- 3:15	Recess	
3:15- 5:00	Panel Discussion: Management of the Diabetic Patient Dr. Beardwood, Dr. Epstein, Dr. Mathers, Dr. Austin	
6:30	Dinner Meeting of the Association—Terrace Room, Johnston's Coffee Shop Guest Speaker: Dr. Otis L. Anderson, Assistant Surgeon General, United States Public Health Service	

FRIDAY, OCTOBER 21 Moderator: Dr. Richard H. Sinden, Incoming President

9:00- 9:45	Pregnancy and Diabetes	Dr. Epstein
9:45-10:30	Insulinomas of the Pancreas	Dr. Beardwood
10:30-10:45	Recess	
10:45-11:05	Hypoglycemia	Dr. Wells
11:05-11:50	Newer Concepts of Diabetes and Mechanisms of Insulin Action	Dr. Epstein
11:50-12:15	Juvenile Diabetes Moderator: Dr. Charles Donegan	Dr. Anderson
2:00- 3:00	The Prevention of Diabetes — Recent Thoughts on the Control of Obesity	Dr. Beardwood
3:00- 3:15	Recess	
3:15- 5:00	Panel Discussion: Management of the Diabetic Patient Dr. Epstein, Dr. Beardwood, Dr. Wells, Dr. Anderson	
8:00	Public Meeting: Daytona Beach Mainland High School Moderator: Dr. Robert L. Miller Speakers: Dr. Beardwood, Dr. Epstein, Dr. Anderson	

October 22 and 23 at the same hotel in Daytona Beach in anticipation that many of the members of the Academy will attend both courses. The rising incidence of diabetes mellitus increases the necessity for an awareness of this disease on the part of all physicians. Dr. Beardwood and Dr. Epstein will address the Academy on Saturday, October 22.

The Committee on Medical Postgraduate Course will make every effort to coordinate such courses in order that a larger group of physicians can attend without materially increased expenses or loss of time.

"Timely Topics"

A monthly publication of the Florida State Board of Health, entitled "Timely Topics," is intended for diabetic patients and is available to any physician who wishes his patients to receive it.

Written in language the average patient can understand, it should be helpful to all who receive it. Perhaps there are many members of the Florida Medical Association who will appreciate this reminder to make sure their patients with diabetes are getting it.

The June issue of this bulletin, for example, consists of an article which might be of as much interest to the average physician as to his diabetic patient. "Beware of 'Sure' Cures" is the title, but the author, Miss Marjorie M. Morrison, Chief Nutrition Consultant of the Board of Health, thought it might well have been called "In Defense of Doctors." Replying to the frequent criticism that doctors withhold information from the public or guard it too closely, she cites the Salk vaccine publicity with the reminder that Dr. Salk received no monetary remuneration and never claimed 100 per cent effectiveness for the vaccine. Likewise, Banting and Best made no money out of their discovery of insulin and claimed only that it would help the diabetic patient live with his diabetes.

In summary, "something sure is better than an advertised cure." Physicians do not make the lavish claims that are routine with fakers and food faddists. For that very reason, they are too frequently ignored in favor of the quacks who, with their clever sales talks, will offer their wares in the interest not of the welfare of man but of how much money they can extract from him.

Why are diabetic patients particularly susceptible to the wiles of quacks? One of the chief reasons, in the opinion of Wallace F. Janssen of the Food and Drug Administration, is dislike of the use of a needle for the administration of insulin. Freedom from the injections is too tempting a thought to withstand. Yielding to the blandishments of the quack may cost the patient with severe diabetes his life, and the patient with a mild or moderate form of the disease eventually learns the error of his choice.

"Why bring up all this anyway?" the article concludes. "Because Florida is fast becoming a mecca for food faddists and quacks. Health-restoring foods and medicines are being pushed to the public — more frequently on a door-to-door basis or "free lecture" plan than any other. It is an appeal to you to remember that when medical science makes a discovery such as insulin and polio vaccine, it is freely given to the public.

"A man's judgment is not any better than his information! Be informed about your diabetes by competent medical authorities."

New Drug Bottle Sets Dangerous Precedent

After all, there is something new under the sun. Seemingly with diabolical ingenuity, an eastern bottle company has thought up a new and surely unique product, which it is now marketing — a clown prescription bottle to be used by druggists in packaging medicine intended for children. No wonder a pharmaceutical manufacturer dubbed the whole idea "a silly merchandising promotion," to put it mildly.

"If it is so psychologically attractive to the child because of the bottle being clown-shaped, then will it not tempt the child to take more of the medication than the doctor prescribed?" he asked. "This temptation," he continued, "especially when parent or guardian is not around, creates an 'overdose situation' which can be very serious indeed." It is understandable that he urged someone to "kill the idea" because, as he said, "medicine is not a top!"

The clown prescription bottle was written up in a recent issue of the American Druggist at the same time a story emanating from the U. S. Food and Drug Administration was urging parents to "keep modern medicines out of their children's reach to avoid tragic consequences." The federal agency presently is concerned with the problem of protecting children against deceptive-looking medicines and has issued a call for a national conference of drug experts to study the matter.

In an editorial on a Florida study of the kerosene hazard to children, published in the April Journal, Katherine Bain, Associate Chief of the United States Children's Bureau was quoted as saying that "roughly two thirds of the deaths from accidental poisoning could be wiped out if aspirin, barbiturates, kerosene, lye, lead, and arsenic were unavailable to small children." The Florida Medical Association at its recent meeting endorsed the present effort of the Florida Children's Commission and the Florida State Board of Health to have a law enacted requiring proper labeling of small kerosene containers sold commercially. This measure should prove as effective as the state's lye legislation, passed years ago, in protecting children from these sources of poison.

Now along comes the clown prescription bottle to lure the child and prove a constant temptation. Will it become necessary to legislate that innovation out of existence? How commercial can we get?

STATE NEWS ITEMS

The fifteenth annual meeting of the Gulf Coast Clinical Society will be held in Pensacola on October 27 and 28, 1955. Approximately 400 physicians in general and specialty practice throughout Southern Mississippi, Southern Alabama and Northwest Florida will be in attendance. This meeting has been approved by the American Academy of General Practice for formal training requirements.

Guest speakers and their subjects on Thursday, October 27, include Dr. John C. Krantz Jr., Professor of Pharmacology, University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore, "Mechanism of Action of the Antibiotic Drugs;" Dr. W. K. Keller, Professor of Psychiatry, University of Louisville School of Medicine, Louisville, Ky., "Gynechiatry;" Dr. Max Michael Jr., Professor of Medicine, New York University College of Medicine, New York City, "The Patient with Fever of Unknown Origin;" Dr. J. E. Miller, Radiologist to the Baylor University Hospital, Dallas, Texas, "Angiocardiography;" and Dr. Grant E. Ward, Director, Tumor Clinic, Johns Hopkins Hospital, Baltimore, "Tumors Primary in the Neck." During the luncheon hour a round table discussion on "Etiology and Treatment of Bronchiogenic Carcinoma" is scheduled.

On Friday morning the guest lecturers and their subjects are: Dr. Edwin R. Levine, American College of Chest Physicians, Chicago, "Mechanisms Responsible for Recurrent Bronchopulmonary Infection;" and Dr. Lester R. Dragstedt, Professor of Surgery, University of Chicago, The School of Medicine, Chicago, "New Light on the Etiology of Gastric and Duodenal Ulcer." A clinicopathologic conference will be the closing feature of the program with Drs. Michael, Dragstedt and Miller, and Dr. W. A. D. Anderson, Professor of Pathology, University of Miami School of Medicine, Coral Gables, participating.

Dr. Walter C. Payne, of Pensacola, is president of this society, and Dr. Barkley Beidleman, also of Pensacola, serves as secretary-treasurer.

Dr. Joshua M. Price of Live Oak was honored by the Kiwanis Club there at a meeting held in August. Club members dedicated their meeting to him in recognition for his more than 50 years of service to the city and county.

Dr. Herman K. Moore of Key West was principal speaker at a recent meeting of the Lions Club of Key West. He recounted some of his experiences during a month's postgraduate course at Vienna, Austria.

Dr. Sidney Smith of Bradenton was guest speaker at a mid-August meeting of the Lions Club of that city. He discussed heart diseases.

Dr. Maurice Kovnat of Miami Beach delivered a scientific paper at the Third World Assembly of the Israel Medical Association held recently at Haifa. Dr. Kovnat is a member of the American Physicians Committee of the Association.

Dr. Albert Lehmann of Pensacola discussed the development of anesthesia and surgery at an early August meeting of the Rotary Club of that city.

Dr. John W. McClane Sr. of Fernandina Beach was principal speaker at the regular meeting of the Rotary Club there early in August.

Dr. Frank G. Slaughter of Jacksonville was featured speaker at a recent meeting of the Civitan Club of that city. The title of his address was "The Usefulness of Useless Knowledge."

Dr. David A. Newman of Palm Beach has returned from Boston where he completed a postgraduate course at the Peter Bent Brigham Hospital in that city.

Urologists from Clearwater, Tampa, St. Petersburg, Sarasota and Bradenton met in Bradenton early in August for the first in a series of meetings to be held by urologists practicing in this area. Dr. Frederic H. Wood of Bradenton was host to the group.

Dr. Wilson T. Sowder of Jacksonville was honored September 15 by employees of the State Board of Health on his tenth anniversary as state health officer. The theme for the hour long program was "A Decade of Progress." Speakers included Dr. John D. Milton of Miami, president of the Florida Medical Association, Dr. R. A.

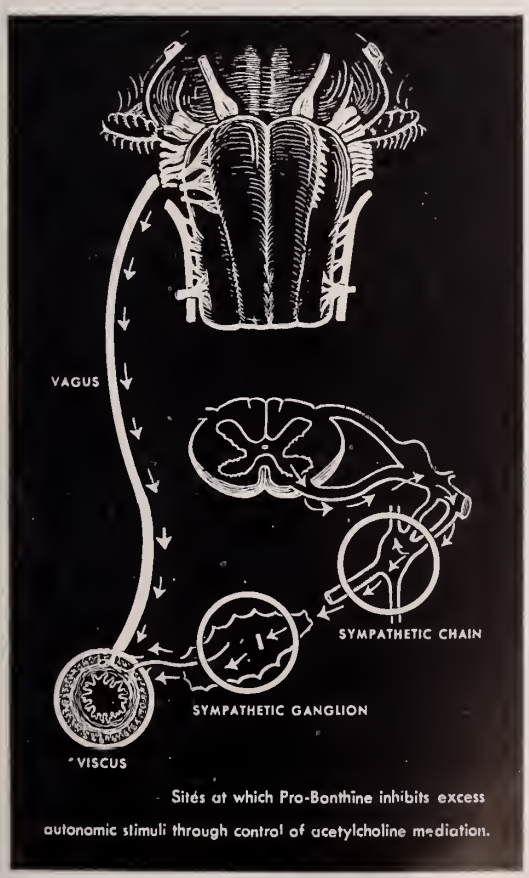
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For the average patient one tablet of Pro-Banthine (15 mg.) with each meal and two tablets (30 mg.) at bedtime will be adequate. G. D. Searle & Co., Research in the Service of Medicine.

1. Schwartz I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: Gastroenterology *25*:416 (Nov.) 1953.
2. Roback, R. A., and Beal, J. M.: Gastroenterology *25*:24 (Sept.) 1953.

SEARLE

Vonderleher of Atlanta, regional medical director, U. S. Public Health Service, and Senator Fletcher Morgan. Dr. Sowder was presented a gold watch on behalf of Board of Health employees.

Dr. Jack A. Sloane of Orlando entered medical service with the U. S. Army in June, 1955, with the rank of captain.

Dr. Robert G. Rosser Jr. of Jacksonville entered medical service with the U. S. Armed Forces on May 8, 1955, with the rank of major.

Dr. Louis Salhanick of Hialeah entered medical service with the U. S. Navy on August 30, 1955, with the rank of lieutenant commander.

Dr. Thomas Whitehead and Dr. James R. Nieder of Delray Beach were principal speakers at the mid-August meeting of the Rotary Club of that city. They reported on progress of the proposed hospital for south Palm Beach county.

COMPONENT SOCIETY NOTES

Dade

Dr. Robert E. Zellner, of Orlando, chairman of the Committee on Economics of the Florida Medical Association, was guest speaker at the September meeting of the Dade County Medical Association. His subject was "The Function of the Committee on Economics as It Pertains to Professional Liability Insurance."

Lake

Dr. Geoffrey H. Binneveld, of Leesburg, was principal speaker at the August meeting of the Lake County Medical Society. His subject was "Medicine in Korea and Japan." Dr. J. Basal Hall, secretary of the Society, reports that members have just completed the immunization and physical examinations for the National Guard Units. This is the eighth consecutive year that this public service has been rendered. He also states that the Society has a 100 per cent paid up membership.

Suwannee

Dr. J. Harry Hayes, of Little Rock, Ark., associate clinical professor of surgery and chief of thy-

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roid surgery at the University of Arkansas School of Medicine, addressed a meeting of the Suwannee County Medical Society on August 16. His subject was "The Diagnosis and Treatment of Thyroid Disorders."

The Society has paid 100 per cent of its state dues for 1955.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Altman, Donald H., Miami
Bruce, John R., Jasper
Burke, Edward, Fort Myers Beach
Burroughs, Lyle W., Tampa
Gladsden, Norman, Miami
Henry, Richard A., Brooksville
Lesser, Milton E., Miami Beach
Menta, Julius D., North Miami
Reid, Robert W., Key West
Rumberger, Wilson A., Fort Myers
Russ, Zack Jr., Tampa
Yantis, Earl E., Ocala

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Seymour Morse of Jacksonville announce the birth of a son, Todd Fleet, on July 24, 1955.

Dr. and Mrs. Albert D. Rood of Jacksonville announce the birth of twin daughters, Debra Lynn and Rebecca Ann, on August 8, 1955.

Dr. and Mrs. David S. Kenet of Lakeland announce the birth of a son, Robert Owen, on July 11, 1955

Dr. and Mrs. Jacob Neber of Miami announce the birth of a daughter, Jennifer Frances on August 14, 1955.

Marriages

Dr. James B. Byrne of Coral Gables and Miss Catherine Frances Butler were married July 30, 1955, in Miami.

Dr. Benton B. Perry of Miami and Miss Roxanne Marilyn Mann were married July 24, 1955, in Baltimore, Md.

Deaths — Other Doctors

Ferguson, John A., Wyckoff, N. J.	June 9, 1955
Kline, Bernard, Mayview, Pa.	May 19, 1955
Maloney, Frank G. H., Madison, Wisc.	May 19, 1955
Porter, Joseph Y. Jr., Key West	August 7, 1955
Scheffel, Carl, Miami	July 18, 1955
Wonka, Warren J., Sarasota	July 19, 1955
Simpson, David J. (Col.), Lakeland	August 22, 1955
Ritch, Una F., Jesup, Ga.	Jan. 10, 1954
Myers, Dean W., Ann Arbor, Mich.	July 2, 1955
Byrd, Edwin S., Atlanta, Ga.	July 7, 1955



Medical Officers Returned

Dr. William T. Steele, who entered military service on July 1, 1953, was released from active duty on June 30, 1955 with the rank of captain, U. S. Army. His address is Coker Building, Winter Haven.

Dr. David R. Rothrock, who entered military service on July 5, 1953, was released from active duty on July 5, 1955 with the rank of captain, U. S. Army. His address is 735 Opa Locka Blvd., Miami.

Dr. James D. Moody, who entered military service on July 2, 1953, was released from active duty on July 15, 1955 with the rank of captain, U. S. Army. His address is 4 E. Sturtevant, Orlando.

Dr. H. Herlong Adams, who entered military service on August 1, 1953, was released from active duty on July 31, 1955 with the rank of major, U. S. Army. His address is P. O. Box 852, Starke.

WANTED — FOR SALE

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Acting specifically on the central nervous system,
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In clinical trials, patients respond with ". . . lessening of tension, reduced irritability and restlessness, more restful sleep, and generalized muscle relaxation."[2]
It is a valuable adjunct to psychotherapy.
Clinical use is not limited by significant side-effects, toxic manifestations, or withdrawal phenomena.[1,2]

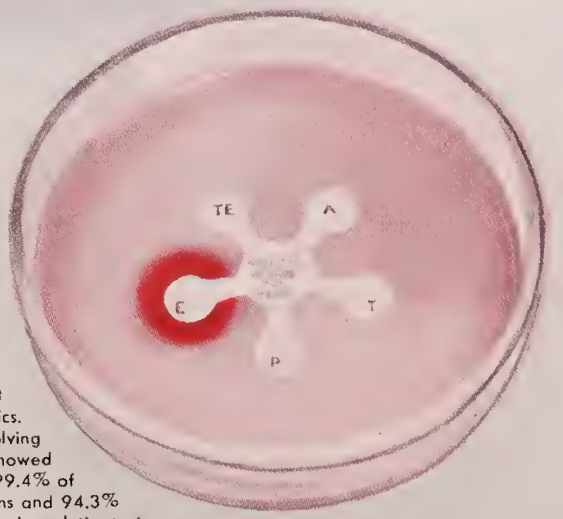
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1. Selling, L.S.: J.A.M.A. 157: 1594 (April 30) 1955. 2. Borrus, J.C.: J.A.M.A. 157: 1596 (April 30) 1955.





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1. Eisenberg, et al., Antib. & Chemo., 3 1026-1028, Oct., 1953.

with little risk of serious side effects

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Medical Licenses Granted

Dr. Homer L. Pearson Jr., Secretary of the State Board of Medical Examiners, has reported that of the 354 applicants who took the examination of the Board, held June 27 and 28, 1955, in Jacksonville, 297 passed and have been issued licenses to practice medicine in Florida. The names and addresses of the 297 successful applicants follow:

Acton, Rush Keith, Miami, (Northwestern 1955)
Allen, John Darlen, Louisville, Ky. (Harvard 1941)
Anderson, George Arthur, Jacksonville (Bowman Gray 1947)
Anderson, Hildreth Vernon II, Knoxville, Tenn. (Louisiana State 1954)
Andrews, John William, Atlanta, Ga. (Emory 1955)
Andrews, William Wallace III, (Col.), Tampa (Meharry 1955)
Archer, Benjamin Lester, Homestead (Geo. Washington 1948)
Axler, Morton Mitchell, Miami Beach (U. Pennsylvania 1950)
Ayres, Thomas William, Shreveport, La. (Virginia 1950)

Babcock, Roy Huston, Sanford (Vanderbilt 1955)
Barish, Landis, Orlando (Hahnemann 1953)
Bass, Haskell Harris Jr., Bradenton (Tulane 1955)
Bechtold, John Edmond, Belleville, Ill. (Washington 1947)
Beck, John Edwin, Decatur, Ga. (Virginia 1939)
Behen, William C., Lansing, Mich. (Pennsylvania 1917)
Benson, Jerome, Miami (Creighton 1948)
Bergquist, Francis Layton, Key West (Arkansas 1949)
Birely, Beverly Robert, Fort Lauderdale (Maryland 1951)
Bitzer, Emory West Jr., Ocala (Virginia 1955)
Blackman, Allan Lee, New York (New York 1948)
Bonura, Charles Meyer, Fort Lauderdale (Tulane 1955)
Booher, David Oscar, Jacksonville (Jefferson 1949)
Boothby, Richard Joseph, Jacksonville (New York 1954)
Borken, Norman, Perry Point, Md. (N. Y. Med. 1949)
Bourne, Paul Samuel, Walkerton, Ind. (Indiana 1953)
Branch, David Louis Jr., Augusta, Ga. (Georgia 1954)
Brown, Glenn Crisman, Miami (Tulane 1953)
Brown, John Ollis, (Col.), Tuskegee, Ala. (Meharry 1950)
Brown, Marjorie Elaine Tweedt, Coral Gables (Marquette 1948)
Brown, Seymour, St. Louis (Washington 1940)
Bryan, James Randall, Augusta, Ga. (Georgia 1953)
Bunch, Rob Royce, Coral Gables (Washington 1952)
Burns, Emil Eddy, Atlanta, Ga. (Emory 1955)
Burnside, Charles Ray, Festus, Mo. (Washington 1951)

Cahn, Burton, Philadelphia (Hahnemann 1955)
Cain, William Joseph, Milwaukee (Marquette 1954)
Camp, Robert Judson, Miami (Virginia 1955)
Carey, Thomas Brandon, Lantana (Albany 1944)
Carney, Robert Tobias, St. Petersburg (Bowman Gray 1954)
Carter, William Everett, Nashville, Tenn. (Virginia 1946)
Cassady, John Rue, Park Forest, Ill. (Indiana 1953)
Cassidy, Robert Edward, New Orleans (Cincinnati 1953)
Catanzaro, Charles, Tampa (Jefferson 1946)
Cauble, John Archie, Atlanta, Ga. (Emory 1954)
Celano, Eugene Robert, Pensacola (Tulane 1955)
Cerrato, Calvin M., Braintree, Mass. (Bologna 1936)
Chambers, William Eldridge, Miami (Pennsylvania 1955)
Clark, George Alexander, New Augusta, Ind. (Indiana 1954)
Clements, Stephen Preston Jr., Boston (Harvard 1955)
Cofrin, David Austin, Gainesville (Cornell 1947)
Cohen, Richard Louis, Miami (New York 1955)
Coleman, Julian Barrus, Miami (McGill 1952)

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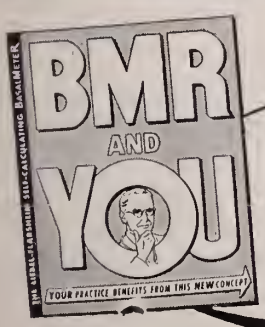
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Collins, John Pope, Durham, N. C. (Duke 1944)
Cooper, William Calhoun Jr., Birmingham, Ala (Emory 1955)
Corey, Arthur Edwoode, Sanford (Tulane 1954)
Crane, Edwin Duff III, Atlanta, Ga. (Emory 1955)
Cranford, James Abram Jr., Jacksonville (Duke 1951)
Crider, Harry Jackson Jr., Orlando (Georgia 1951)

de la Penha, Daniel Simon, Augusta, Ga. (Georgia 1953)
Delgado, Robert Earl, Miami (Emory 1955)
Delman, Abner Joseph, New York (New York 1955)
Derry, William Hewitt, Miami (Colorado 1949)
Dickerson, Edzell Phenon, Orlando (Emory 1955)
Dobelle, Martin, Pittsfield, Mass. (Ghent 1934)
Doggett, Thaddeus Hill, Memphis, Tenn. (Tennessee 1947)
Donegan, Charles Coleman Jr., Charlottesville, Va. (Virginia 1951)
Donovan, Raymond Flowers, Watseka, Ill. (Illinois 1932)
Doster, John Roxie Jr., Jacksonville (Georgia 1952)
Douglas, Robert Arnold, Homestead (Maryland 1952)
Dyal, John Alexander Jr., Jacksonville (Georgia 1952)

Edgerton, Norman Bruce, Palatka (South Carolina 1943)
Erickson, George Matthews, Miami (Buffalo 1949)
Ewing, Channing Lester, Jacksonville (Virginia 1952)

Failla, John Anthony, Greenfield, Mass. (Boston 1939)
Faris, William Elbert, New Orleans (Tulane 1949)
Faust, William Raymond, Ocala (Temple 1955)
Featherston, John Smith, Key West (Geo. Washington 1946)
Feld, Harold, St. Petersburg (Cincinnati 1938)
Fergeson, James Oliver, St. Petersburg (Arkansas 1945)
Ferguson, James Henry, Miami (Pennsylvania 1939)
Fishel, John Lewis, Winston-Salem, N. C. (Duke 1953)
Flanagan, Curtis James, Miami (St. Louis 1952)
Fleming, William Henry II, Augusta, Ga. (Georgia 1951)
Fogel, Morris, Brooklyn (Boston 1936)
Forizs, Lorant, Butner, N. C. (Ferencz Jozsef 1936)
Fortunato, Stephen J., Providence, R. I. (Virginia 1937)
Foss, Harold Gregory, Chicago (Loyola 1951)
Foster, Donald Harvey, Pitman, N. J. (Jefferson 1954)
Foxworthy, Donald Lewis, Indianapolis (Indiana 1951)
Frankel, Donald Benjamin, Miami (Illinois 1942)
Frazier, Donald Benjamin, Jacksonville (Geo. Washington 1946)
Fritz, George Suppes, St. Petersburg (Maryland 1954)
Fuerst, Howard Jay, Montgomery, Ala. (Pennsylvania 1949)
Furlong, Paul James, West Haven, Conn. (New York 1951)
Galin, Miles A., Brooklyn (Bellevue 1955)
Gartner, Lee Darrell, Lincoln, Neb. (Nebraska 1949)
Geathers, Edward William, (Col), Winter Haven (Meharry 1954)
Geiger, Albert James Jr., Atlanta, Ga. (Emory 1955)
Gibson, Clyde Ellis, Bartow (Emory 1955)
Glattauer, Alfred, Brandenburg, Ky. (Zurich 1940)
Goldmeier, Erich, Perry Point, Md. (Frankfurt 1938)
Golia, Ernest Arthur, Bartow (Tufts 1940)
Gould, Purdue Leighton, Minneapolis (Washington 1948)
Graham, Angus Woodward Jr., Miami (Vanderbilt 1955)
Gray, Clell Claborne Jr., Miami (Cincinnati 1946)
Gregory, Laurence William, Sarasota (California 1925)
Griffin, Joseph Allan, Chicago (Loyola 1951)
Griffith, Henry Winter, Miami Springs (Emory 1953)
Guest, James Lee Jr., Atlanta, Ga. (Emory 1955)
Haddad, Maurice, Tampa (Beirut 1945)
Hahn, Theodore Wallace, Belle Glade (Louisville 1954)
Hall, Charles Clinton, Orlando (Evangelists 1954)
Hall, Kenneth Daland, Durham, N. C. (Duke 1953)
Hampton, John Bullock, Tampa (Emory 1955)
Hanks, Jack Billie, Atlanta, Ga. (Emory 1955)
Hardee, Erasmus Bacon Jr., Vero Beach (Virginia 1955)
Harle, Harold Lewis, Gainesville (Southwestern 1954)
Harrell, George Neville Jr., Plant City (McGill 1953)
Harris, Harry, Miami (Tufts 1924)

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Harris, Robert Scharff Jr., Miami (Tennessee 1954)
Harrison, Henry Tucker Jr., St. Petersburg (Virginia 1954)
Haupt, Clara Pucic, Gainesville (Pennsylvania 1940)
Hegert, Thomas Frederick, Orlando (Nebraska 1954)
Helfrich, Norman Alexander Jr., Jacksonville (Georgetown 1953)
Hobdy, Charlie Joe, Nashville, Tenn. (Vanderbilt 1955)
Hooper, Donald, Attalla, Ala. (Alabama 1954)
Hoover, Robert Theron, Orlando (Evangelists 1953)
Hopkins, William Benjamin Jr., Tampa (Harvard 1948)
Horton, James Allen, Live Oak (Louisiana 1954)
Huntley, Arthur Carson, Fort Lauderdale (Jefferson 1955)
Hurst, Ralph Emerson, Winter Park (New York 1949)
Hyams, Robert Gabriel, New York (Columbia 1939)

Iglesias, Robert Garcia, Tampa (Havana 1948)
Ira, Gordon Henry Jr., Jacksonville (Duke 1955)
Isaacson, Sherwin, Rochester, N. Y. (Chicago 1948)
Jackson, Andrew Rudolph, (Col.), Tampa (Meharry 1954)
Janulis, Peter Theodore, New York (Cornell 1951)
Jelks, Allen Nathaniel, Fort Lauderdale (Duke 1955)
Jenkins, William Jones, Augusta, Ga. (South Carolina 1943)
Johnson, Reginald Hall Jr., Durham, N. C. (Duke 1950)
Johnston, Harry Buchanan, Atlanta, Ga. (Georgia 1953)

Kaplan, Allan Arthur, Miami Beach (New York State Col. 1950)
Katibah, George Mitchell, Jacksonville (Emory 1955)
Keiser, Lester, Philadelphia (Jefferson 1950)
Kemp, William Lloyd, Birmingham, Mich. (Michigan 1953)
Kilgore, William Enloe, Ocala (Emory 1955)
Kimbell, Fariss Derring Jr., Warrington (Tulane 1946)
Kinsella, Dalton Louis Jr., Miami (St. Louis 1947)
Kirkman, Henry Neil, Tallahassee (Johns Hopkins 1952)
Klorfein, Elliott Harry, West Palm Beach (Tulane 1955)
Koenig, Alfred Daniel, St. Petersburg (Lausanne 1942)
Kruger, Harold Fred, Fort Lauderdale (Michigan 1940)
Kuhn, Charles Phillip, Miami Beach (Ohio State 1952)

Lamphier, Timothy Andre, Natick, Mass. (Boston 1943)
Larkum, Newton Wheeler, Hagerstown, Md. (Virginia 1941)
Lasche', Eunice Marie, Tampa (Temple 1948)
Leb, Herbert Scott, Miami Beach (St. Louis 1955)
Lees, Irving Balcom, Grand Rapids, Mich. (Long Island 1949)
Leonardy, John George Jr., Coral Gables (Emory 1955)
Lewis, Alfred Lawson Jr., Amite City, La. (Tulane 1954)
Lewis, Charles William Jr., Jacksonville (Duke 1945)
Lichtblau, Sheldon A., Long Beach, N. Y. (Chicago 1953)
Lien, Ira Jay, Miami Beach (Col. P. & S., Boston 1949)
Liles, Royall Thomas Jr., New Orleans (Tulane 1949)
Lockwood, Wayne Babcock, St. Augustine (Pennsylvania 1954)
Lopez, Joseph George, Miami (Louisiana 1948)
Lowrey, Daniel Bernard, Birmingham, Ala. (Washington 1950)

McCall, Ben Waring, Jacksonville (Duke 1955)
McCormick, John Theus, Jacksonville (Georgia 1953)
McIntosh, Charles Byron, (Col.), Jacksonville (Meharry 1955)
McKenna, Robert Joseph, New York (Cornell 1951)
McKey, Robert Milroy Jr., Miami (Vanderbilt 1955)
McVey, John Lovett, Newton Highlands, Mass. (Boston 1955)
Macris, Jack Achilles, Coral Gables (Michigan 1950)
Mabie, Paul David, Camp Lejeune, N. C. (Cincinnati 1954)
Major, James Moffat, Decatur, Ga. (Emory 1953)
Makol, James George, Springfield, Mass. (Beirut 1943)
Maxwell, William, New York (Long Island 1920)
Mazza, Peter Anselmo, Pelham, N. Y. (Italy 1933)
Mellion, Anson Joel, Jacksonville (New York 1954)
Melvin, Hiram Mack, Milton (Tulane 1955)

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RICHMOND 9, VIRGINIA

Michele, Arthur Albert, Brooklyn (New York 1935)
Miles, Clifford Burton, Chicago (Northwestern 1952)
Miller, Andrew Herron, Columbia, S. C. (Tennessee 1947)
Miller, Hyman I., Kew Gardens, N. Y. (Middlesex 1943)
Millis, James Brown, Wabassa (Tennessee 1955)
Minor, Byron Donald, Atlanta, Ga. (Emory 1955)
Mitchell, John Lewis, Jacksonville (Emory 1955)
Mix, George Henry, Tacoma, Wash. (Buffalo 1947)
Moore, Louis Stone, Thomasville, Ga. (Zurich 1954)
Moore, Michael Judson, Virginia Beach, Va. (Virginia 1948)
Moore, Richard Benjamin Jr., Union City, Tenn. (Vanderbilt 1955)
Morton, Donald Gene, Miami Beach (Oklahoma 1953)
Murray, James Beverley, Willoughby, Ohio (Western Reserve 1946)

Nardone, Robert Rudolph, Beaufort, S. C. (Tufts 1947)
Neefe, John Robert, Philadelphia (Pennsylvania 1940)
Neill, James Robert, Coral Gables (Emory 1955)
Newton, Emory O'Neal, Bartow (Emory 1955)
Newton, Lyle Arford, Jacksonville (Nebraska 1930)
Nickell, Leo Carroll, Orlando (Louisville 1951)
Nogueiras, Humberto Mario, Miami (Havana 1949)

O'Brien, Fred Kevin, Palm Beach (Tulane 1955)
O'Conor, Gregory Thomas, W. Hartford, Conn. (Cornell 1948)
O'Neill, Philip Bernard, St. Simons Island, Ga. (Pittsburgh 1941)
Orestano, Andrew, Tampa (Tulane 1955)
Oyen, William, Winter Garden (Illinois 1949)

Padgett, Glenn Ernest, Marianna (Geo. Washington 1953)
Parker, Mayon Vann, Durham, N. C. (Duke 1953)
Patten, Robert Chester, Miami (Cornell 1954)
Patterson, Lawrence George, Waupaca, Wis. (Ohio 1931)
Pavlik, Charles Emanuel, Miami (Albany 1954)
Pendergrass, Henry Pancoast, Wynnewood, Pa. (Pennsylvania 1952)
Perloff, Milton Leon, Miami Beach (Hahnemann 1955)
Perry, Gerald Francis, Westbury, N. Y. (Madras 1943)
Peterson, Donald Laing, Hollywood (Minnesota 1933)
Phinizy, John, Lincolnton, Ga. (Georgia 1953)
Preefer, Charles J., Rockville Centre, N. Y. (Tufts 1930)
Pringle, James Copeland Jr., Montgomery, Ala. (Johns Hopkins 1953)
Pucic, Catherine Jean, Trafford, Pa. (Pittsburgh 1938)
Pund, Ernest Evers Jr., Augusta, Ga. (Georgia 1955)

Quarterman, Keith Axson Jr., Atlanta, Ga. (Emory 1955)

Raisbeck, Clifford Clinton Jr., Warrington (Northwestern 1953)
Raker, Ned Tyson, Lima, Peru, S. A. (Jefferson 1935)
Rattray, Charles Frederic Jr., Pineville, La. (Alabama 1954)
Rawls, Thompson Townsend, Rochester, Minn. (Harvard 1949)
Rechbook, Karl Yaskin, Miami Beach (Pennsylvania 1955)
Regan, Thomas Francis, Lake City (Pittsburgh 1946)

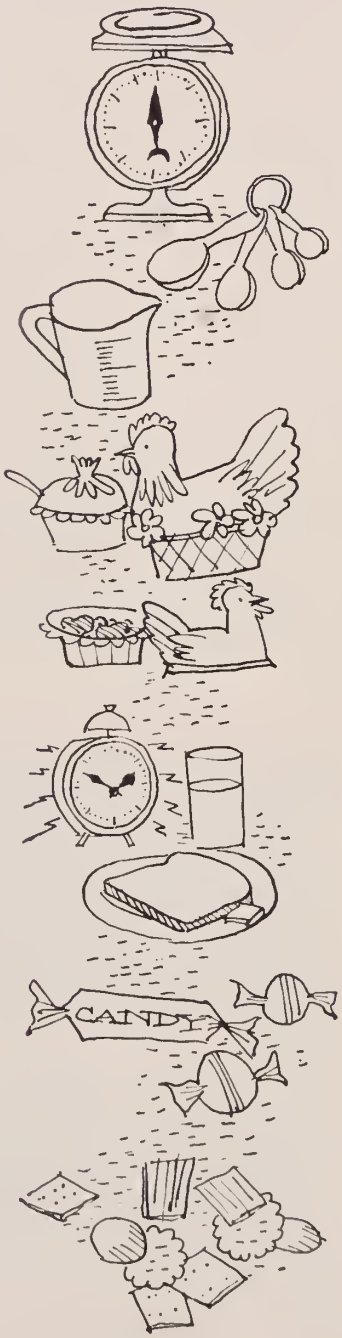
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Your patient may feel an outsider both at home and away from home when diabetes upsets his eating habits. Of course, a measured diet is vital. The trick is to fit that diet as closely as possible to the patient's personal preferences and way of life. Here are some diet "do's" to help in planning the menus.



At home—

Try to adapt favorite recipes to the diabetic diet. Then select vegetables, beverage, and fruit or dessert to complete the diet prescription for the meal.

Suggest that measured portions be served in dishes that fit the serving. A small portion on a large plate is not a happy prospect.

Where possible, let your patient use a food exchange list. He'll delight in the variations it provides.

Away from home—

Explain that insulin demands food with the urgency and regularity of an alarm clock. If a dinner party will be late, suggest a light snack at the usual mealtime with a corresponding caloric reduction in the delayed meal.

Allow extra carbohydrate for extra activity. And have your patient carry hard candies as a precaution against insulin reaction.

If possible, plan low-calorie wafers in the diet for times when others nibble canapés or chocolates.

A diet that fits in smoothly with your patient's family and social life means you'll have his fullest co-operation, and he'll lead a happier life.

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*Average of American beers

Rester, James Harvey Jr., Lantana (Louisiana 1944)
Rew, John Bernard, New Orleans (St. Louis 1953)
Richmond, Kenneth Comstock, Miami (Rochester 1954)
Ritch, Joseph George Jr., Stuart (Tennessee 1955)
Robinson, Joe Sam, East Point, Ga. (Georgia 1944)
Rogers, David Ross, Fort Lauderdale (Virginia 1948)
Rosenthal, Anna, Miami (New York 1948)
Rosenthal, Martin, Brooklyn (New York 1955)
Ross, Irwin Randall, Philadelphia (Hahnemann 1955)
Rowars, Howard, Whitestone, N. Y. (Munich 1936)
Ruder, Ernst Murphy, Clearwater (Emory 1955)
Russell, Albert Barnard Jr., New Orleans (Tulane 1955)

Salmon, William Davis Jr., St. Louis (Vanderbilt 1949)
Salvatore, Joseph Enrico, Philadelphia (Hahnemann 1955)
Sanford, Marshall Clement, Gibson Island, Md. (Johns Hopkins 1942)
Schiess, Retha Renee Rudloff, Miami (Bowman Gray 1953)
Schindler, Richard Elias, Miami (Maryland 1953)
Schmierer, Elmer John, Wildwood (Louisville 1954)
Schrantz, Freeman S., Miami (Tennessee 1940)
Schulman, Harold, N. Miami (Emory 1955)
Schutt, James Bourie, Ligonier, Ind. (Indiana 1931)
Schwalbe, Frank Conrad Jr., Baltimore (Emory 1955)
Scudder, Harry Greene, West Palm Beach (Temple 1952)
Shaver, William Alvin, Augusta, Ga. (Pennsylvania 1948)
Sheffel, Donald David, Miami (Leiden 1954)
Simons, Robert Baldridge, Warrington (Colorado 1934)
Skaggs, Thomas Wayne, Miami (Maryland 1953)
Smith, Ballard Franklin, Rochester, Minn. (Buffalo 1946)
Smith, Richard Brooks, New Orleans (Indiana 1944)
Smythe, John Welden, Winter Haven (Jefferson 1948)
Specht, Harry Otto, Indianapolis (Indiana 1948)
Stanton, Robert Lowell, Coral Gables (Temple 1953)
Stapp, Lee Mannen, South Miami (Emory 1955)
Stefan, Ladislav, Winter Haven (Prague 1945)
Stein, Benjamin Frederick, Mount Carmel, Ill. (Illinois 1941)
Steinmetz, Rodney Dunlap, Rochester, Minn. (Northwestern 1952)
Stephens, David Lamar, Tallahassee (Tulane 1949)
Stough, Dowling Bluford III, Tampa (Arkansas 1953)
Szekely, Gabriel, Miami Beach (Bologna 1935)

Tanis, Arnold Lawrence, Key West (Chicago 1951)
Tate, Charles Franklin Jr., Charlottesville, Va. (Virginia 1949)
Temple, Van Carlton, Hattiesburg, Miss. (Vanderbilt 1930)
Terragni, Manlio, Bronx, N. Y. (Bellevue 1915)
Thompson, George Allen, Bastian, Va. (Virginia 1954)
Toporoff, George Sherman, West Palm Beach (Pennsylvania 1955)
Trimble, James Rufus, Durham, N. C. (Columbia 1947)
Turnage, Johnson Lee, Crestview (Tulane 1942)
Turner, John Sidney Jr., Lakeland (Emory 1955)

Vadheim, Robert Harold, Gainesville (Minnesota 1944)
Van Arnam, Carleton Everest, Micanopy (Oregon 1953)
Van Eldik, Dick Leroy, Duluth, Minn. (Iowa 1952)

Wadsworth, Gerald Edward, Tampa (Emory 1955)
Ward, John Ardis, Shellman, Ga. (Emory 1950)
Watkins, Lee Clifford Jr., Rochester, Minn. (Harvard 1952)
Watson, William Newton, Milton (New York 1954)
Weekley, Augustine Smythe Jr., Tampa (Boston 1955)
Weeks, Clarke Bankston Jr., Lakeland (Emory 1953)
Weinstein, Pierce, Cocoa (Buffalo 1949)
Werner, Charles Arthur, Huntington, N. Y. (Cornell 1945)
Whorton, Carl Merrill, Jacksonville (Vanderbilt 1940)
Williams, Edward Herbert Jr., Jacksonville (Emory 1955)
Willig, Selwyn Gerald, New Orleans (Tulane 1954)
Wilson, Herbert, Fort Myers (Geo. Washington 1939)
Winter, Willian John Jr., Miami (Pittsburgh 1942)
Wright, Jack Elvin, West Palm Beach (Louisville 1954)
Wynne, Morgan Dozier Jr., Griffin, Ga. (Emory 1955)

(Continued on page 334)

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Practical Knowledge and Realistic Goals Urged by National Auxiliary

During August and the first part of September, programs from the national auxiliary chairmen are sent to every county auxiliary chairman and president urging them to take part in those projects set up at the national level and making suggestions for the augmentation of these programs. In almost every instance, the program has two major aspects — personal knowledge and information and secondly, aid to the community through putting this personal knowledge to use as it applies to our own home towns and communities.

The themes of the national auxiliary have varied from year to year but some of these of the last few years indicate the two major purposes of all national auxiliary programs and here are some examples: *Be an Informed Member, Every Member an Informed Member, Together We Progress, Leadership in Community Health* and the theme chosen by Mrs. Mason G. Lawson for 1955-56, "Active Leadership in Community Health." The sense of the two major aspects is self-evident. To

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Indications: *Rheumatoid arthritis*
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be an active leader in community health, the member of the auxiliary must be an informed member and have knowledge of both the needs of her community and what she can do about it.

Past years have shown that in the Florida Auxiliary we work together and that the tremendous accomplishments we have had, have been realized by the participation of practically every member of every component auxiliary with her local auxiliary and the participation of every component auxiliary in every program of the state and national auxiliary.

State reports come out of the compiled material and reports sent from the component auxiliaries and the record of working together in Florida is easily proved by the number of awards, examples from Florida and other mentions that are given us in increasing number at each national convention. If we try to analyze why we have been so successful in Florida in working together and accomplishing the goals we have set, we believe it could be boiled down to one thing — the realization on the part of the state auxiliary that people learn from each other. An opportunity to learn from each other is given whenever the personnel of the component auxiliaries get together. The informality of our meetings, we believe, lends itself to even the most timid soul having no fear of asking questions and the answers coming not from one person who says it all, but rather from an exchange of experiences between those of one group and those of another. Add to the tolerant and understanding friendship that develops between the various individuals of the various component auxiliaries, that there is never a feeling of anyone taking from another but rather a delight that someone felt what had been done was so well worthwhile that another group wanted to use it, and you have the recipe for our working together and for the success of the Florida Auxiliary.

With the realization that Florida component auxiliaries are from our largest to almost our smallest county and that our component auxiliaries vary in size from 386 members (Dade) to 11 members (Jackson-Calhoun) that one gets the vision of what happens when our whole state is covered, and from all the members of Dade to all the members of Jackson-Calhoun, everyone realizes that the biggest auxiliary doesn't always





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do the best job and that the smallest auxiliary is just as important and many times is more important than the largest. It is with the tolerance and understanding of each other's problems and the give and take of experiences that we work so well together. Yes, the members of the Florida Auxiliary, have learned that every locality is important and that the largest group may often learn from the smallest and vice versa.

If the legislature in Florida worked as well together as do the component auxiliaries, that legislature would, indeed, become a paradise.

Mrs. Richard F. Stover

The annual workshop meetings of the Woman's Auxiliary to the Florida Medical Association are being held October 10, 11, 12 and 14 in connection with the Medical District Meetings of the Association.

(Continued from page 330)

Young, Elbert Lewis, St. Petersburg (Tennessee 1953)
Young, Lloyd Ulin, Cleveland (Virginia 1952)
Young, William Arthur, Natick, Mass. (Toronto 1936)

Zelnick, Saul, Brooklyn (New York 1954)

BOOKS RECEIVED

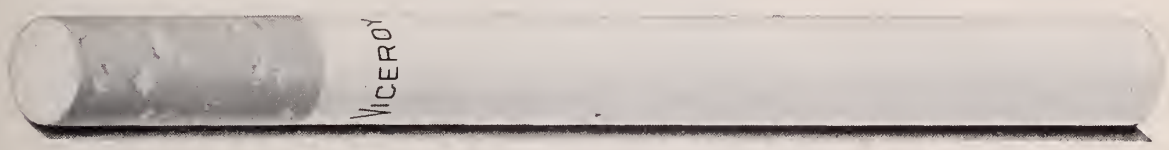
Recent Advances in Medicine and Surgery (19-30 April 1954) Based on Professional Medical Experiences in Japan and Korea 1950-1953. Vol. I, pp. 530. Vol. II, pp. 421. Price, $1.75. Washington 25, D. C.

Listed as Medical Science Publication No. 4, these volumes represent complete notes of a course entitled Recent Advances in Medicine and Surgery conducted by the Army Medical Service Graduate School, Walter Reed Army Medical Center, Washington, D. C., April 19 to 30, 1954. The title, as stated in the preface, is a slight misnomer inasmuch as it was intended by those responsible for the course's design that it reflect primarily the professional experiences, problems encountered and lessons learned by the Army Medical Service during the Korean war. To this end the faculty was selected from persons "who were there," who met and successfully coped with the actual problems and, as a result, could speak with the authority of personal and intimate knowledge of the subject. The student body was drawn from mature clinicians so that a critical discussion of papers could be had prior to final editing for publication. The opinions collected are considered to represent the best thinking on the subject at this time and, in a literal sense, constitute a history of the professional and clinical activities of the Army Medical Service in Korea.

It is hoped that the timely publication of these lessons and their general distribution to Reserve training groups, libraries and medical schools, will help to give better preparation to the next doctors who are called on to treat mass casualties — whether they be as a result of military or civilian disasters.



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Dowling, H. F.: Practitioner *174*:611 (May) 1955.

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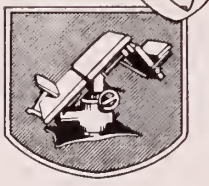
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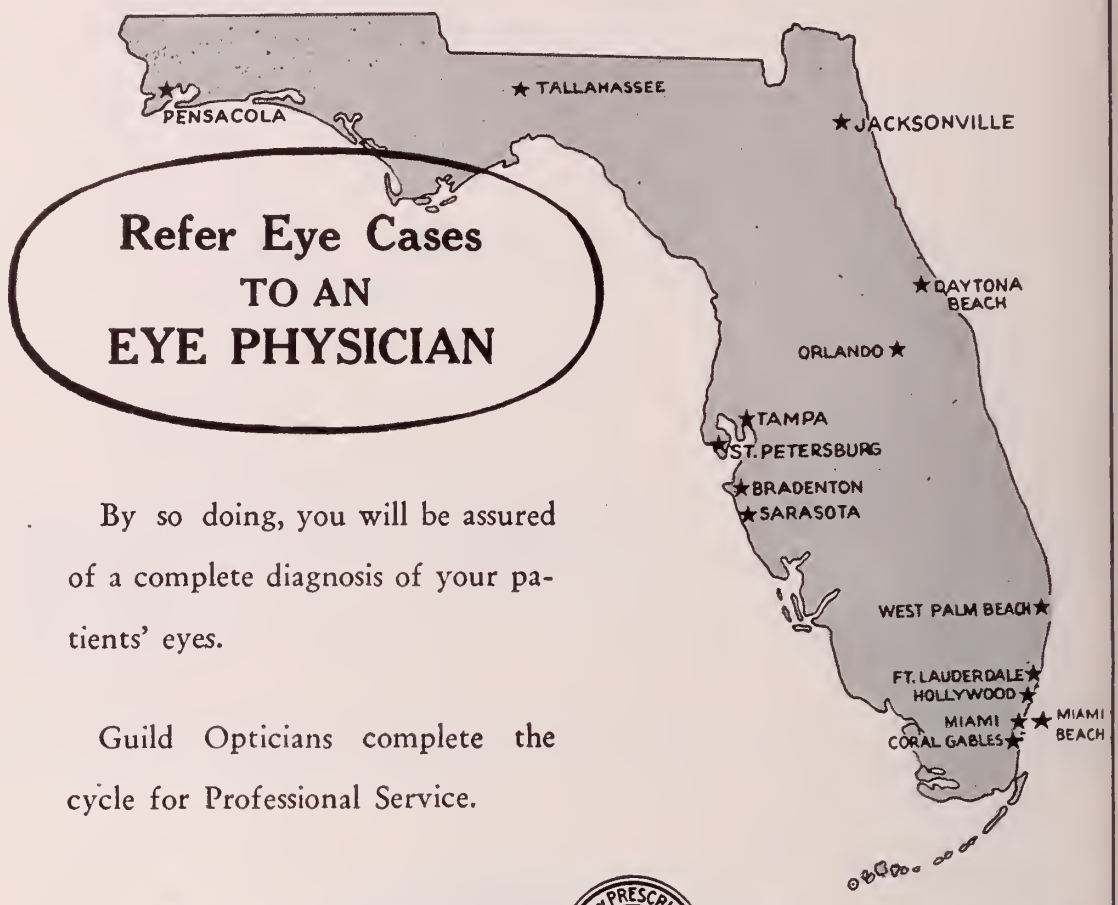
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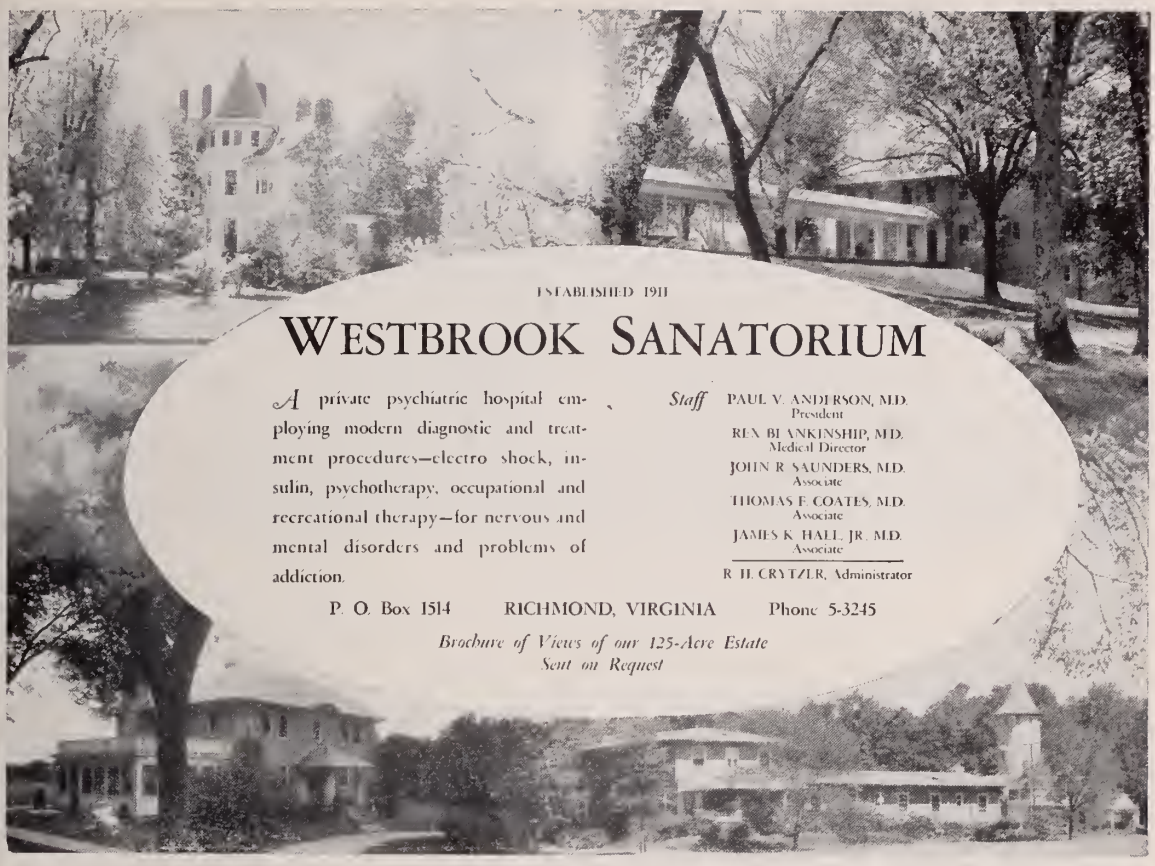
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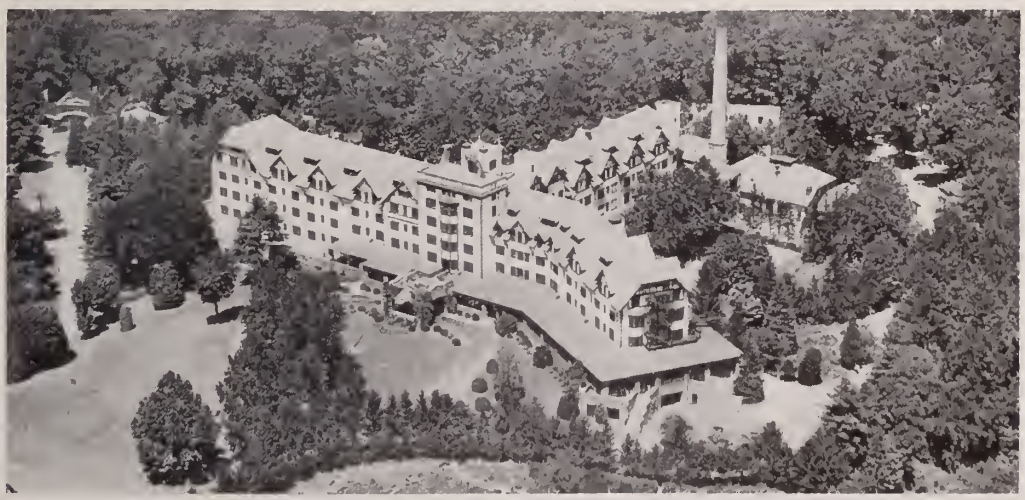
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ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
a Medical Association	John D. Milton, Miami	Samuel M. Day, Jacksonville	Miami Beach, May 13-16, '56
a Medical Districts	Ralph W. Jack, Miami	Council Chairman	
Northwest	William P. Hixon, Pensacola	Walter J. Baker, Foley	Pensacola, Oct. 14, '55
Northeast	Henry J. Babers Jr., Gainesville	Charles L. Park Sr., Sanford	Gainesville, Oct. 12, '55
Southwest	C. Frank Chunn, Tampa	James R. Boulware Jr., Lakeland	Lakeland, Oct. 11, '55
Southeast	James R. Sory, West Palm Beach	Ralph S. Sappenfield, Miami	Fort Lauderdale, Oct. 10, '55
a Specialty Societies			
my of General Practice	Frank T. Linz, Tampa	James B. Hodge Jr., Tampa	Daytona Beach, Oct. 22-23, '55
ey Society	W. Ambrose McGee, W. P. Bch.	Norris M. Beasley, Ft. Lauderdale	Miami Beach, May, '56
esiologists, Soc. of	Wayland T. Coppedge Jr., Jax	William H. Houston, Jacksonville	" " " "
e Phys., Am. Coll., Fla. Chap.	Hawley H. Seiler, Tampa	William L. Potts, Lantana	" " " "
r and Syph., Assn. of	Joseph L. Hundley, Orlando	Kenneth J. Weiler, St. Petersburg	" " " "
al Officers' Society	Clarence L. Brumback, W. P. Bch.	Lorenzo L. Parks, Jacksonville	" " " "
rial and Railway Surgeons	Frank L. Fort, Jacksonville	John H. Mitchell, Jacksonville	" " " "
logy & Psychiatry	Edward H. Williams, Miami	J. Robert Campbell, Tampa	" " " "
id Gynec. Society	J. Champneys Taylor, J'sonville	Reuben B. Chrisman Jr., Miami	Daytona Beach, Oct. 22-23, '55
al. & Otol., Soc. of	Charles W. Boyd, Jacksonville	Kenneth S. Whitmer, Miami	" " " "
pedic Society	Edward W. Cullipher, Miami	Robert P. Keiser, Coral Gables	" " " "
logists, Society of	Millard B. White, Sarasota	Wray D. Storey, Tampa	" " " "
ric Society	Lewis T. Corum, Tampa	Joel V. McCall Jr., Daytona Beach	Ft. Lauderdale, Nov. 3-5, '55
logic Society	Thomas F. Nelson, Tampa	George Williams Jr., Miami	Miami Beach, May, '56
logical Society	Hugh G. Reaves, Sarasota	Donald H. Gahagen, Ft. Lauderdale	Daytona Beach, Oct. 22-23 '55
ns, Am. Coll., Fla. Chapter	Joseph S. Stewart, Miami	C. Frank Chunn, Tampa	" " " "
gical Society	David W. Goddard, Daytona Bch.	W. Dotson Wells, Fort Lauderdale	" " " "
a—			
c Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, Nov. 5, '55
od Banks, Association	Louis E. Pohlman, Orlando	Mrs. Estelle Lieberman, W. P. Bch.	
e Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	St. Petersburg, Dec. 6, '55
e Shield of Florida, Inc.	Russell B. Carson, Ft. Lauderdale	John T. Stage, Jacksonville	
cer Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	Miami Beach, May 13, '56
ical Diabetes Assn.	Sidney Davidson, Lake Worth	Edward R. Smith, Jacksonville	Daytona Beach, Oct. 20-21, '55
tal Society, State	T. A. Price, D.D.S., Miami	W. A. Buhner, D.D.S., Daytona Bch.	Miami Beach, May 28-30 '56
rt Association	Victor H. Kugel, Miami Beach	Edwin P. Preston, Miami	
pital Association	Mr. Pat N. Groner, Pensacola	Mr. Steve F. McCrimmon, C. Gbls.	St. Petersburg, Dec. 8-9, '55
lical Examining Board	Morris B. Seltzer, Daytona Bch.	Homer L. Pearson Jr., Miami	Miami Beach, Nov. 20-22, '55
lical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
se Anesthetists, Fla. Assn.	Miss Dorothy Jackson, C. Gables	Mrs. Lulla F. Bryan, Miami	St. Petersburg, Dec. 6-8, '55
ses Association, State	Martha Wolfe R.N., Coral Gables	Agnes Anderson, R.N., Orlando	Daytona Beach, Nov. 28-30, '55
rmaceutical Assoc., State	Miss Frances Walpole, Sarasota	Mr. R. Q. Richards, Ft. Myers	
lic Health Association	Mr. J. A. Mulrennan, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Daytona Beach, Oct. 20-22, '55
deau Society	Harold W. Johnston, Orlando	Howard M. DuBose, Lakeland	
erculosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mr. Ernest L. Abel, W. Palm Beach	
man's Auxiliary	Mrs. Samuel Lombardo, J'sonville	Mrs. Leffie M. Carlton Jr., Tampa	
can Medical Association	Elmer Hess, Erie, Pa.	Geo. F. Lull, Chicago	Miami Beach, May 13-16, '56
M.A. Clinical Session	Elmer Hess, Erie, Pa.	Geo. F. Lull, Chicago	Chicago, June 11-15, '56
ern Medical Association	Robt. L. Sanders, Memphis, Tenn.	Mr. V. O. Foster, Birmingham	Boston, Nov. 29-Dec. 2, '55
ma Medical Association	F. L. Chenault, Decatur	Douglas L. Cannon, Montgomery	Houston, Nov. 14-17, '55
ia, Medical Assn. of	H. Dawson Allen Jr., Milledgeville	David Henry Poer, Atlanta	Birmingham, Apr. 19-21, '56
Hospital Conference	Mr. D. O. McClusky Jr. Tuscaloosa, Ala.	Mr. Pat Groner, Pensacola	Atlanta, May 13-16, '56
			Miami Beach, Apr. 18-20, '56
eastern Allergy Assn.	Ben Miller, Columbia, S. C.	Kath. B. MacInnis, Columbia, S.C.	Charlotte, N. C., Oct. '56
eastern, Am. Urological Assn.	Sidney Smith, Raleigh, N. C.	Robert F. Sharp, New Orleans	Hollywood, Mar. 25-29, '56
eastern Surgical Congress	Donald S. Daniel, Richmond	B. T. Beasley, Atlanta	Richmond, Mar. 12-15, '56
Coast Clinical Society	Walter C. Payne Sr., Pensacola	Barkley Beidleman, Pensacola	Pensacola, Oct. 27-28, '55

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SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Total Members
Alachua	Edwin H. Andrews, Gainesville	Henry S. Blank, Gainesville	2nd Tues.	55
***Bradford, Gilchrist, Union**				
Bay	William F. Humphreys Jr., Panama City	Roderick C. Webb, Panama City	1st Tues.	28
Brevard	Lee Rogers Jr., Cocoa	Charles E. Russell, Cocoa	2nd Tues.	37
Broward	Ernest E. Serrano, Hollywood	Alfred E. Cronkite, Fort Lauderdale	4th Tues.	121
Columbia	Robert B. Harkness, Lake City	Thomas H. Bates, Lake City	1st Mon.	11
***Baker**				
Dade	L. Washington Dowlen, Miami	Robert F. Dickey, Miami	1st Tues	725
DeSoto-Hardee-Highlands-Glades	Gordon H. McSwain, Arcadia	Harold S. Agnew, Arcadia	1st Tues.	28
Duval	Raymond H. King, Jacksonville	Eugene M. Frame, Jacksonville	1st Tues.	300
***Clay**				
Escambia	George W. Morse, Pensacola	Paul F. Baranco, Pensacola	2nd Tues.	107
***Santa Rosa**				
Franklin-Gulf	Warren T. Weathington. Apalachicola	Joseph P. Hendrix, Port St. Joe	Last Wed.	6
Hillsborough	Frank S. Adamo, Tampa	Julien C. Pate Jr., Tampa	1st Tues.	192
Indian River	Kip G. Kelso, Vero Beach	Vernon L. Fromang, Vero Beach	2nd Tues.	9
Jackson-Calhoun	Henry I. Langston, Marianna	Francis M. Watson, Marianna	Quarterly	17
Lake	Louis R. Bowen, Eustis	J. Basil Hall, Tavares	1st Wed.	29
***Sumter**				
Lee-Charlotte-Collier-Hendry	Baker Whisnant, Fort Myers	James L. Bradley, Fort Myers	3rd Mon.	38
Leon-Gadsden-Liberty-Wakulla-Jefferson	William L. Hunter, Monticello	Odis G. Kendrick Jr.. Tallahassee	Quarterly	66
Madison	A. Franklin Harrison, Madison	Wallace E. Winter, Madison		8
Manatee	Marjorie L. Warner, Bradenton	Harvey C. Pauley Jr.. Bradenton	2nd Tues.	31
Marion	William H. Turnley, Ocala	Bertrand F. Drake, Dunnellon	3rd Tues.	31
***Levy**				
Monroe	Ralph Herz, Key West	William R. Ploss, Key West	1st Thurs.	15
Nassau	David G. Humphreys, Fernandina Beach	John W. McClane, Fernandina Beach	Last Fri.	11
Orange	Don C. Robertson, Orlando	Walter A. Derrick, Orlando	3rd Wed.	192
***Osceola**				
Palm Beach	Edwin W. Brown, West Palm Beach	James R. Anderson, West Palm Beach	4th Mon.	143
Pasco-Hernando-Citrus	Harry G. Brownlee, Zephyrhills	W. Wardlaw Jones, Dade City	2nd Thurs.	17
Pinellas	Clyde O. Anderson, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	227
Polk	Samuel J. Clark, Lakeland	Marion W. Hester, Lakeland	2nd Wed.	101
Putnam	Grover C. Collins, Palatka	Alfred P. Peretti, Palatka	2nd Tues.	10
St. Johns	George C. Hopkins, St. Augustine	Reuben J. Plant Jr.. St. Augustine	3rd Tues.	21
St. Lucie-Okeechobee-Martin	Henry E. Branca, Fort Pierce	Adrian M. Sample. Fort Pierce	3rd Thurs.	24
Sarasota	Melvin M. Simmons, Sarasota	Andrew J. Jesacher, Sarasota	2nd Tues.	58
Seminole	John M. Morgan, Sanford	Terry Bird. Sanford	2nd Tues.	20
Suwannee	William P. Blackmon, Jasper	Hiram B. Curry, Jasper	1st Sat.	11
***Hamilton, Lafayette**				
Taylor	John H. Parker Jr., Perry	Ralph J. Greene. Perry	Last Fri.	5
***Dixie**				
Volusia	Robert L. Miller, Daytona Beach	Achille A. Monaco, Daytona Beach	2nd Tues.	84
***Flagler**				
Walton-Okaloosa	Richard H. Lee, Crestview	Frederic E. Caldwell. Fort Walton Beach	3rd Tues	20
Washington-Holmes	L. H. Paul. Bonifay	Bayllye W. Dalton. Chipley		5
			Total	2.803

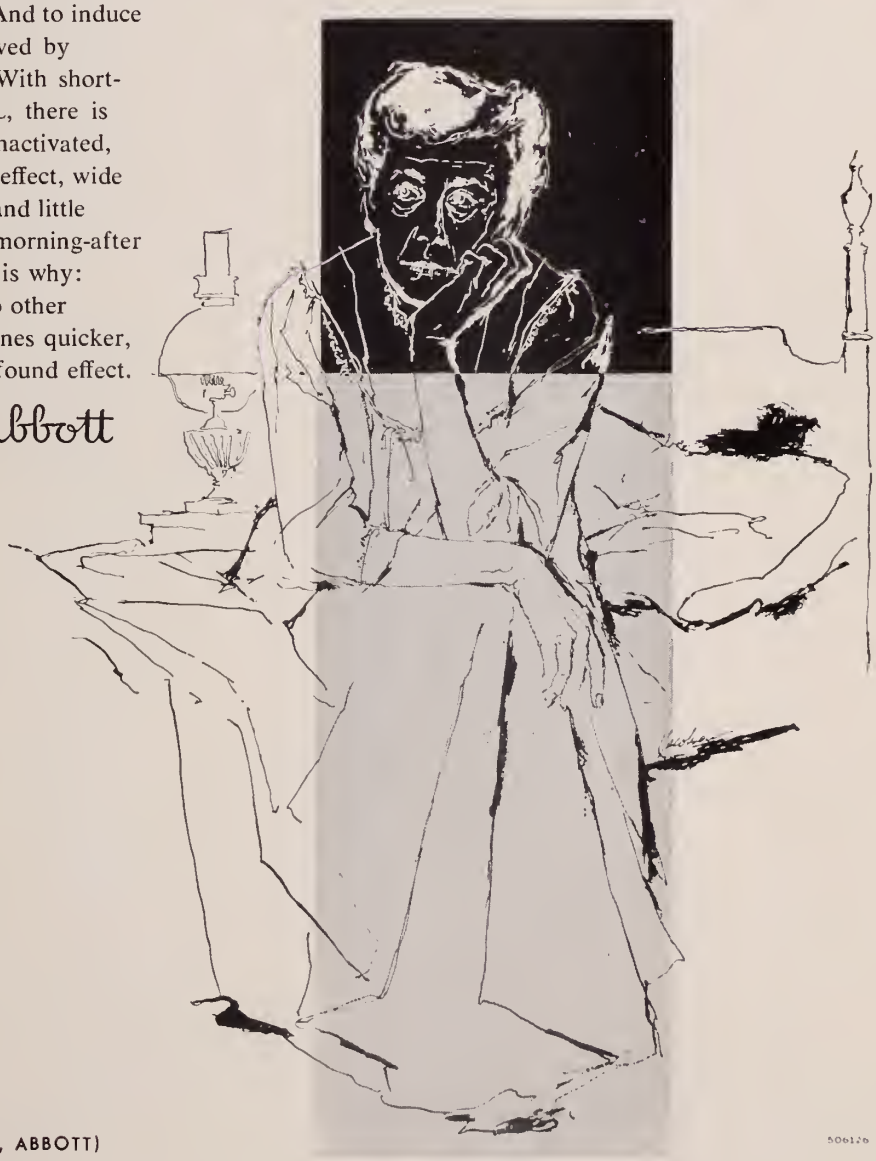
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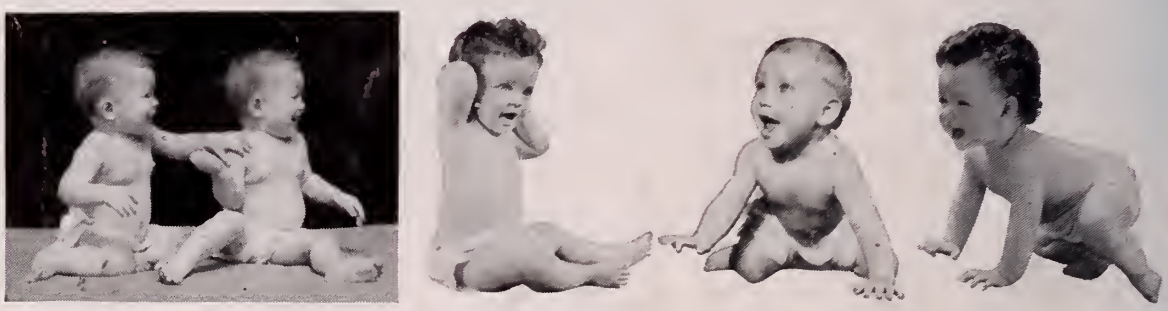


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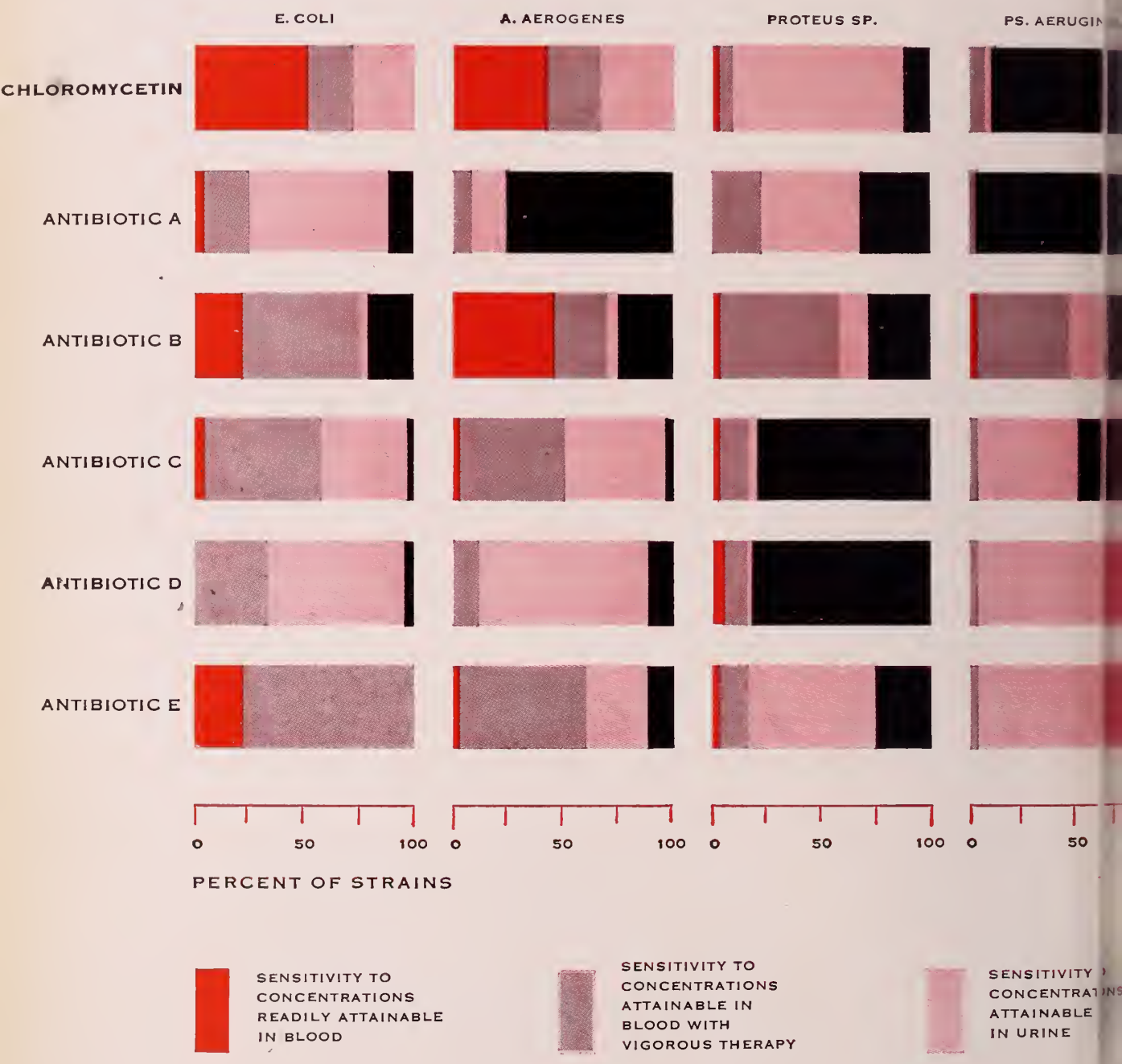
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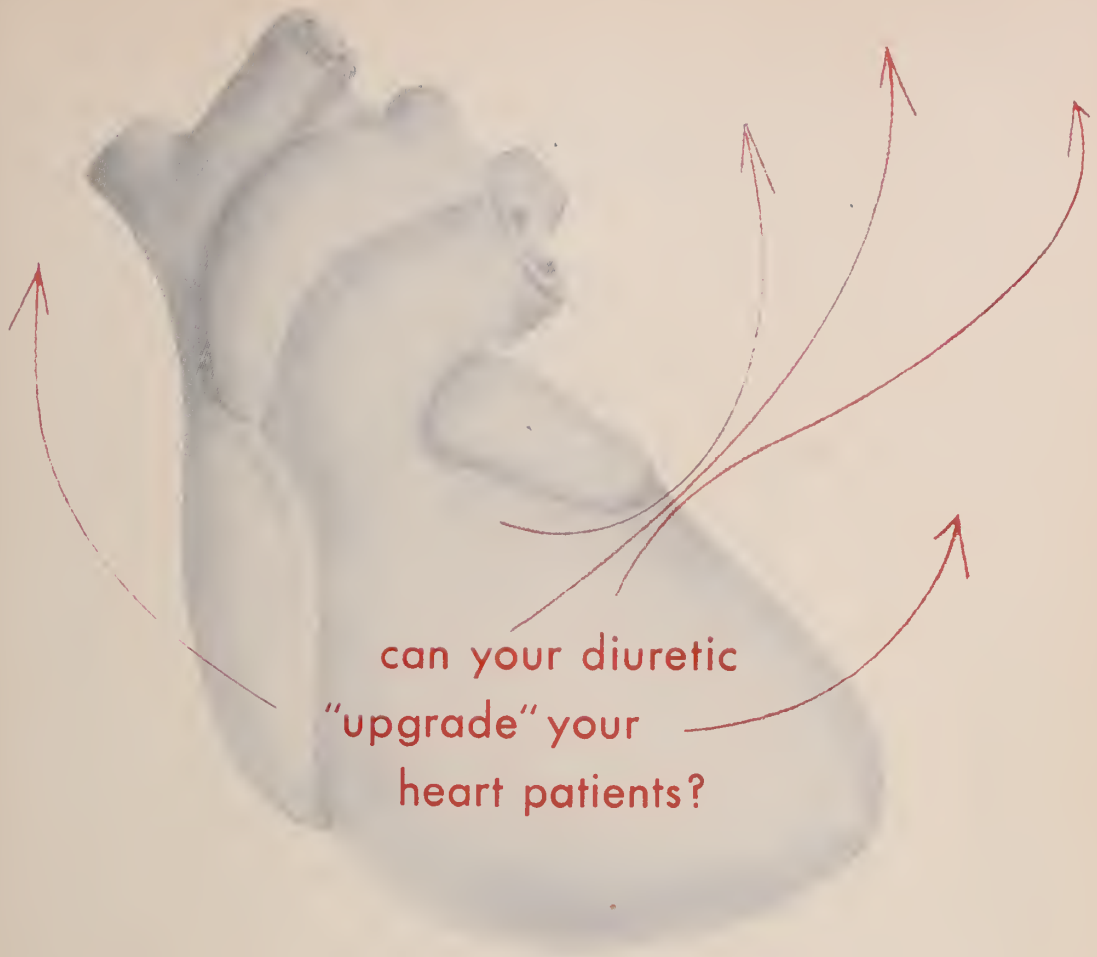
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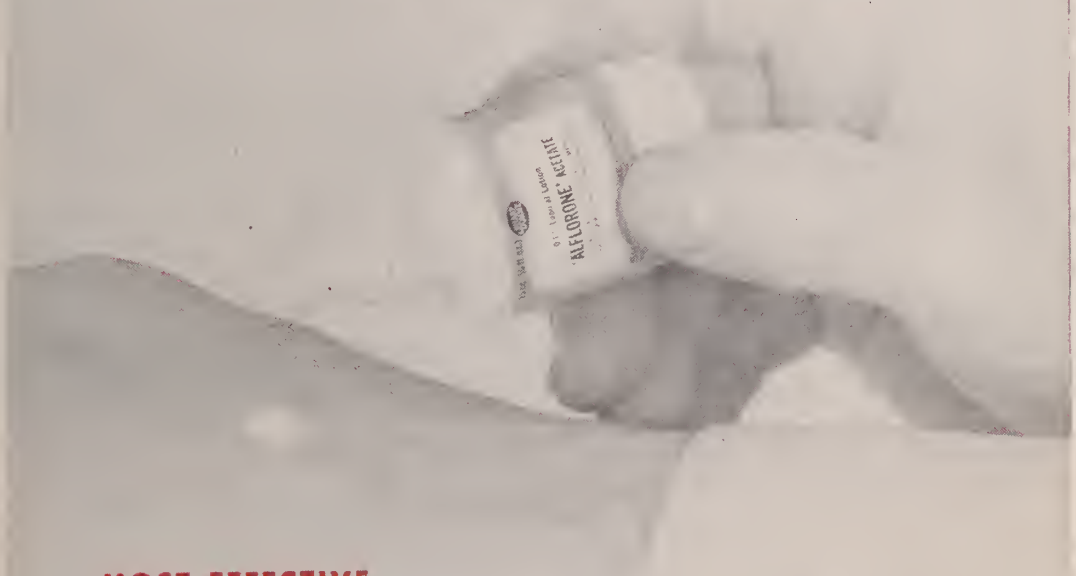
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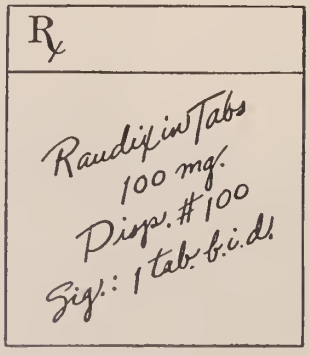
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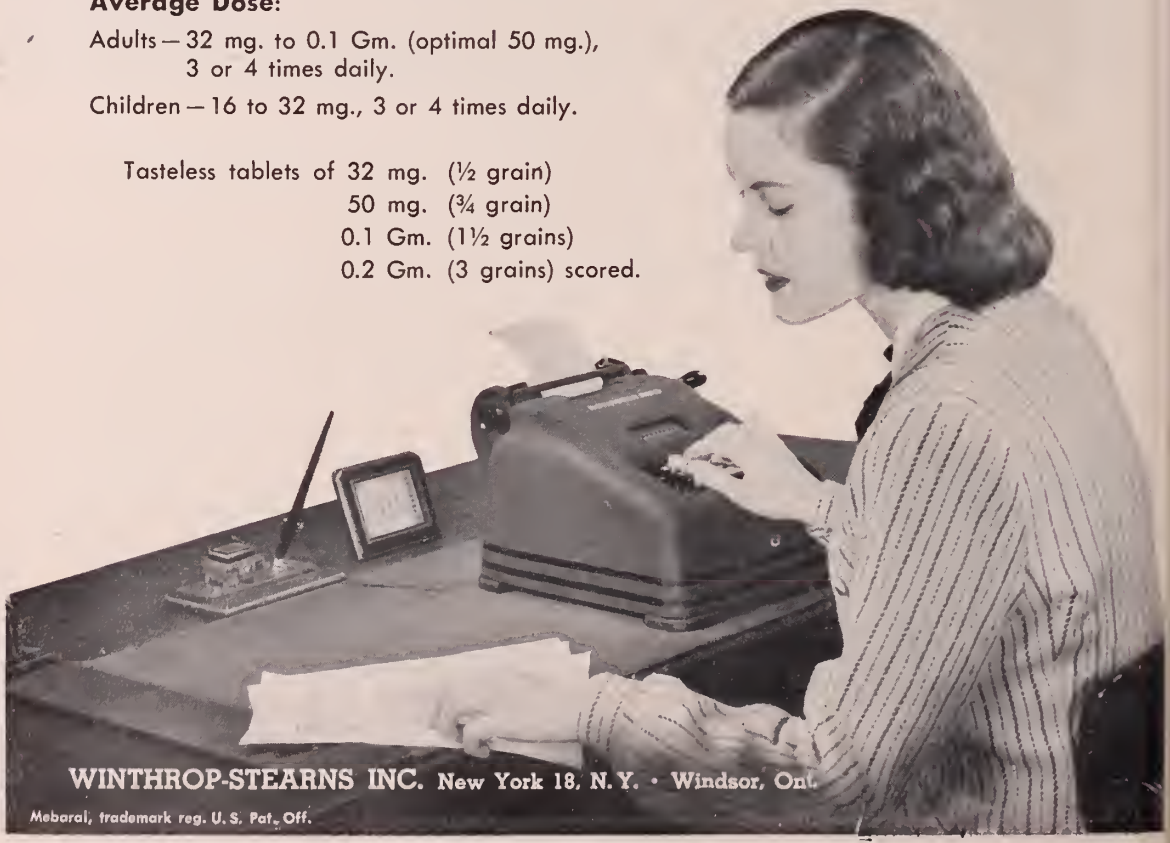
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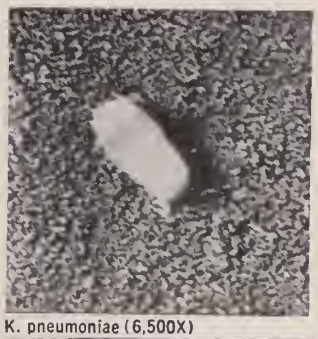
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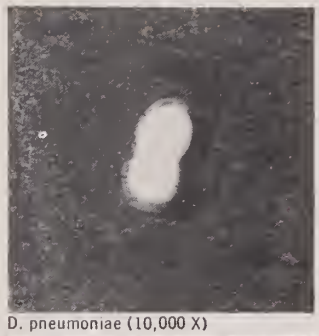
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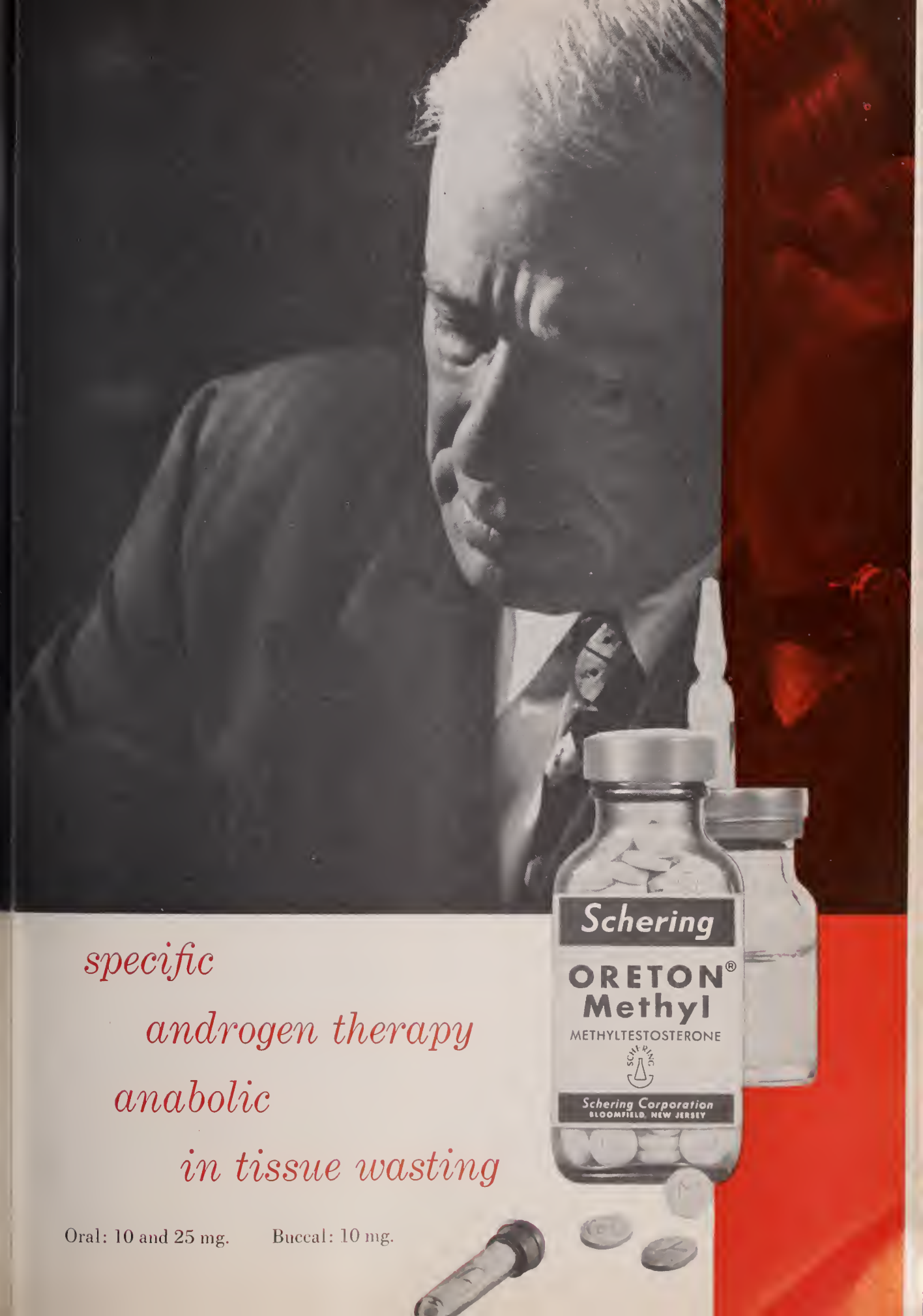
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Contact Dermatoses From Everyday Exposures

George E. Morris, M.D.
BOSTON

The practising physician who is presented with a patient having an eruption of the exposed or even the nonexposed parts of the body must first differentiate whether the rash arises from a substance external to the body or from the internal organs. To do so adequately, one must have as a prime requisite a good foundation in the common skin diseases and, in order to make a correct diagnosis of contact dermatitis, one must first suspect that the patient has such a condition. A knowledge of the various substances which are causing contact dermatoses among other people should prove of great aid to the doctor making the diagnosis.

In the questioning of a patient with suspected contact dermatitis, the first question to be asked is, "Have you ever had any previous eruption, and if so, what was its cause?" The patient is then asked if he or she knows anything that might make the skin burn or itch, or which irritates or makes the skin turn red.

Once these questions have been answered, it is time to inquire if the patient has bought or used any new products of late. In this connection, however, it is well to remember — as is often evidenced in my practice — that some patients have been exposed to the same chemicals for over 25 or 30 years and then have suddenly broken out from exposure to them, with the fact being definitely established that there has been no new chemical introduced into the patient's environment. While there is a natural tendency to look for new products, it is, therefore, well to remember also that new products are not at all necessarily to be found, and that, for instance, products regularly contacted by the patient may have undergone changes in their formulary which are unknown to the buyer.

It is also to be kept in mind that the patient's skin may change, and this is the "X" factor in all contact dermatitis. I have recently seen a man in whom there first developed a contact dermatitis from exposure to rubber fumes at his work; within two weeks he became sensitive to the nickel in his wrist watch and in his watch band, as well as to the plastic of his eyeglasses. In this particular case, while the eruption from the rubber appeared first, and may have changed the patient's skin, it is more likely that the patient's skin itself had changed and that, then, these three substances, which never before had bothered him, suddenly commenced to do so.

If the history, taken as indicated, furnishes no clue as to the etiology of an eruption, then the physician must treat the patient according to the principles laid down herein, and on each visit renew his searching questions for causes of irritation, burning or redness. The eruption sometimes must be almost completely gone before the patient notices anything that could prove to be the irritating factor.

In the diagnosis of contact dermatitis, then, the doctor starts as a physician, and turns detective; once his detective work is over, he returns in his capacity as a physician and heals his patient. Once the suspicion of a contact dermatitis has been engendered in the mind of the physician, he must persist in his quest until he has either proved his point or found some other cause for the dermatitis. Thus, I have never made a diagnosis of "housewife's eczema," for to my mind that is the same as no diagnosis at all. In my practice, what is generally referred to as "housewife's eczema" may be due to anything from

Read before the Florida Medical Association, Eighty-First Annual Meeting, St. Petersburg, April 6, 1955.

soaps, detergents, hamburger, floor wax and furniture polish to any of the multitudinous substances that women handle in their everyday duties; or the eruption may be due to the ingestion of food, to a bacterial agent, to a focus of infection in the body, or to the innumerable other substances or conditions that make the diagnosis of hand skin cases of interest.

Commonest Causes of Contact Dermatoses Seen By a Skin Specialist

Overtreatment

The commonest eruptions seen amongst patients coming into the dermatologist's office are those that arise from "overtreatment." The patient who cuts, bruises or burns himself is sometimes treated by a doctor, but more often has been given well-meaning advice by a nurse, a friend or a pharmacist, who tells him to bandage the affected area with such-and-such a salve, inasmuch as that had cured some friend or relative with a like condition. In such circumstances, instead of the patient getting better as a result of such "treatment," frequently there develops an acute erythematous and vesicular eruption from the applied medication (fig. 1). This is what is



Fig. 1. — Overtreatment dermatitis: ointment applied to insect bites.

termed "overtreatment dermatitis." Many papers have been written about this condition, but few of the authors have given adequate stress to the proper treatment. At this point, therefore, I insert a summary of the principles of therapy of contact dermatitis,[1] so that at least some of the eruptions may be obviated.

(A) Types of Eruptions

A rash may either be acute or chronic (or subacute, which, however, is not considered herein). An acute dermatitis occurs when new lesions continue to develop although the rash may have been of long standing. Thus, although a patient may have had psoriasis for a long time, if new lesions are developing within a month or so of the examination, then he has what is known as acute psoriasis, and must be treated for an acute dermatitis. As a practical matter, then, the application of such medications as mercury, tar, and chrysarobin, which for years have proved of value in psoriasis, will most certainly result in disaster if applied to the lesions of acute psoriasis.

A dermatitis is chronic when the patient has had lesions for a long time, which have been unchanging, and when no new lesions have developed for a period of two or three months. The dermatologist rarely sees a patient with a chronic dermatosis, as in general, if the rash is not getting worse or bothering the patient, he seldom consults either a general practitioner or a skin specialist.

(B) Treatment of Acute Contact Dermatoses

Most contact dermatoses are acute, since the patient usually has a red or vesicular eruption; therefore, the medications to be used are those which obtain in the treatment of acute dermatoses in general — baths, compresses, powders and lotions, as follows:

(1) BATHS. — If the patient suffers from a generalized eruption, cold or cool starch or vinegar baths allay itching and cool the skin.

Starch baths are made by mixing two cups of cornstarch with cold water to form a paste. Two quarts of boiling water are then added, and the mixture is poured into a cool bath. The patient should sit in the tub for 10 to 15 minutes and allow the starch water to run all over the body. A half cup of vinegar may be added to such a starch bath to increase its astringency. The patient should dry himself by patting — not by rubbing. One or two such baths a day may be indicated in the acute case.

Vinegar baths are made by adding one-half to one cup of vinegar to a bath.

Patients who complain of itching or burning or redness after a starch bath must be suspected of being allergic to cornstarch. In such a case, the use of a different type of starch, such as potato or rice starch, or the change to a vinegar bath may be indicated.

(2) COMPRESSES. — If the eruption is more localized, then cool or cold compresses (not dressings) may be used, along with cool baths. Compresses are to be applied with a cloth to the affected parts, and after a few minutes the cloth

is to be removed. Dermatologists rarely bandage dressings.

Common compresses that are helpful contain sodium chloride, or boric acid in a 1 to 2 per cent solution, or solution of aluminum acetate, diluted 1/20 or 1/40, or Dalibour's water. Dalibour's water is composed of

Copper sulfate	10.0
Zinc sulfate	30.0
Water	120.0

This is diluted, one teaspoonful to a quart of cold water, and is excellent for pyogenic lesions.

(3) Powders. — Dusting powders are especially useful in treating acute dermatoses. Such powders cool and protect the skin.

Dusting powders are generally mixtures of four to six ingredients, and usually contain talc, a stearate, zinc oxide, and a carbonate, in the desired proportions.

(4) Lotions. — Although lotions are of some value in treating acute dermatoses, the trouble is that the patient is apt to apply them too thickly, thereby defeating the purpose for which they are prescribed. Actually a lotion is a suspension of an insoluble powder in a liquid. Lotions, therefore, combine the characteristics of compresses and of powders. They are used for the same purpose. Upon their application, the water evaporates and cools the parts, leaving a powder which further aids in the evaporation of water from the skin, thus causing a cooling sensation.

Calamine lotion is the one most used, but should it contain phenol, it should never be bandaged on an extremity. Generally speaking, it is best made without phenol.

(5) Antihistamine Tablets. — The oral administration of antihistamine tablets may or may not relieve itching. A trial of a few days is worth while if itching is severe. They should not be administered continuously if they are found not to benefit the individual patient.

(6) Sedatives. — Sedation in acute dermatoses is a hazard, for hypnotics and sedatives, such as the barbiturates and chloral, often serve only to make the patient semicomatose, so that he will scratch the eruption while in a stupor, thereby aggravating the condition.

(7) Steroids. — ACTH and cortisone have been reported by some physicians to be useful in the treatment of acute dermatoses, but I am not yet convinced, and therefore have eschewed their usage.

A word of caution is called for at this juncture in regard to the use of ointments: Although useful in the therapy of chronic dermatoses, they frequently make acute dermatoses worse. They are mixtures of active ingredients in a grease or in a greaselike substance. Often a patient will tell his physician that the ointment that he applied to his poison ivy made him worse, or that the salve that he purchased or which was recommended to him "burned" him and caused his eruption to spread. In fact, as intimated, this is one of the commonest complaints registered in a dermatologist's office.

New Products. — In connection with the treatment of contact dermatoses, there are a few new products on the market which I think should be called to the attention of the general practitioner:

1. A new form of tar, known as Zetar,* can be removed from the skin with water, whereas previously tars had to be softened either by olive oil or by a solvent, and were not cosmetically "elegant" for the skin.

2. A second new product which has come to my attention is Sortkwik,† which is excellent as an applicant to the fingers in that a little rubbed onto the thumb and first finger permits one to handle papers, cards and currency with ease and celerity, thereby dispensing with the use of rubber fingers, to which many persons are allergic.

3. A third new product worthy of note is a liquid hand cleaner known as Scriptoil,‡ which removes paint, tar, pitch, putty, cutting oils and other similar hard-to-remove substances promptly and without irritation.

4. Finally, the Domeboro Powders,§ which represent a modern packaged form of Burow's solution, and take the place of the old-fashioned solution of aluminum acetate N.F., have great possibilities.

With these principles of dermatologic therapy in mind, and by the use of the products mentioned, many of the "overtreatment dermatoses" can be prevented.

I have devoted quite some space to the commonest cause of contact dermatoses, "overtreatment," but have done so deliberately because of its great incidence and because it is generally overlooked by general practitioners.

*Zetar is manufactured by the Dermik Pharmacal Co., Inc., Brooklyn 12, N. Y.

†Sortkwik is manufactured by Lee Products Co., 2736 Lyndale So., Minneapolis 8, Minn.

‡Scriptoil is prepared by the Scriptoil Laboratories, 143 Federal St., Boston 10, Mass.

§Domeboro Powers are manufactured by Dome Chemicals, Inc., 109 W. 64th St., New York 23, N. Y.

Other Common Causes

The second commonest cause of nonindustrial contact dermatoses comprises the detergents and soaps which are continually handled by the housewife (fig. 2). Detergents may be roughly categorized into two types: Fine fabric detergents and heavy duty detergents. The fine fabric detergents cause little trouble to the skin, but the so-called heavy duty detergents are the cause of much irritation amongst housewives. When heavy duty detergents are used, the wise housewife will wear cloth gloves under rubber gloves for such exposures. Strong soap and ammonia solutions also irritate the hands, and here again the precaution of cloth and rubber gloves is indicated. It must be remembered[2] that the use of hot water must be forbidden to these patients.



Fig. 2. — Bullous dermatitis: from use of heavy duty detergent.

In my office, patients who complain of itching or burning from the use of one of these detergents are instructed to wear white or grey cotton gloves under rubber gloves whenever they wash their dishes or clothes; and they are advised to use one of the neutral fine fabric detergents in cold water. Many physicians have inquired how I have been able to get patients to follow these instructions. I have had no trouble in that regard; I just tell them that this is the way to combat the condition, and if they do not want to do it that way, they are not to return to me for treatment. I have yet to see one case in which the patient refused to follow these instructions, when the reasons were properly presented. In my experience, when one has a vesicular eruption of the hands, the hands cannot be placed in hot water without a flare-up of the condition occurring.



Fig. 3. — Dermatitis of arm on right from perfume.

Third among the commonest causes of eruptions in these patients is poison ivy. This condition is accompanied by vesicles and bullae, usually of the arms and legs, but also of other parts of the body at times, and is characterized by linear lesions. The physician will be wise to remember that most dermatoses of internal origin are of circular or serpiginous outline, whereas many of the external contactants cause straight-sided and angular lesions.

The next commonest cause of eruptions is the use of cosmetics, perfumes and other toiletries. It is customary to think that an eruption develops at every site where a perfume is applied, but this is not so. The accompanying photograph (fig. 3) shows the contact dermatitis of one antecubital fossa from a perfume, but the perfume had been applied to both arms equally, according to the patient. Dermatoses of the eyelids are generally caused by nail polish, but also may be due to eye creams, eye shadows, eye curlers, face creams, neck creams, hair preparations, hand preparations, hat material, and almost any other material that anyone can mention, even including attic dust.

The fifth among the commonest causes of eruptions among people in general is clothing. There have been reported outbreaks of dermatitis from the finish of clothing, from the dye of

clothing, and from the rubber in girdles. Dermatoses also occur from leather gloves, cement in shoes, chrome in shoes, and pocket material; and wool, nylon and any other material worn may sometimes in certain persons cause dermatitis.

A particularly common cause of dermatitis, especially in women, is the metal nickel which commonly causes dermatitis of the lobes of the ear or in the garter areas. In this regard, it is interesting to inspect such patients carefully. Recently I had a girl patient who had a dermatitis of both ear lobes. While she had six garters fastened to her stockings, three on each side, at only one site of the six did she have an erythematous, scratched and itchy eruption: the five other places of contact with the nickel were entirely normal. In my practice, I have found it to be essential, when treating these patients, that they not be allowed to contact nickel at any site. Thus, this girl patient was told to put pads under her garters, to remove the small metal pieces in the straps of her brassiere and slip, not to wear a white gold wrist watch, and not to wear earrings. In other words, all nickel exposure was removed from her body. Only in this way can the condition in these patients be cleared up. Similar removal of all chrome-containing material is essential to the clearing of chrome dermatitis.[3]

Such materials as the pollen of ragweed may cause a dermatitis, especially in mid-August in New England.

The use of solvents in the removal of paint, tar, and pitch is another frequent cause of dermatoses.

Then, certain suspectible persons have had eruptions proved to be due to dog hair, facial masks, newsprint, and a host of other materials that are found in everyday life. No single material can categorically be said not to have caused some eruption in some person, and it is with such a basis that the physician starts his search, for as soon as he says that it cannot be thus, he has closed his eyes to a potential cause.

Summary

The most frequent causes of dermatoses occurring in the common man are enumerated. "Overtreatment" is the one most commonly encountered in this group, and accounts for more than 50 per cent of the entire number of cases.

The principles of dermatologic therapy are briefly reviewed.

Almost any substance can cause an eruption in certain susceptible persons.

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Outpatient Treatment of Tuberculosis

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The availability of effective antituberculosis drugs in the past few years has renewed interest in the outpatient treatment of tuberculosis. Outpatient treatment before or instead of hospitalization has no doubt been practiced rather widely, but the results have not been well documented.

Perhaps the best report is that of Robins and his associates in New York City, who treated 494 outpatients with isoniazid and PAS without restriction of activity. Eleven per cent discontinued treatment voluntarily within four months, 6 per cent showed worsening by roentgen examination within six months, and in only 52 per cent of those examined at the end of six months' treatment had the sputum been converted to negative. This result is in contrast to that in 94 per cent of hospitalized patients treated with the same drugs for the same period whose sputum or gastric contents were negative to culture in a study conducted under the auspices of the United States Public Health Service.

From this and from other less well reported studies it would seem clear that outpatient treatment of tuberculosis should not be attempted before or instead of hospitalization if hospital beds are available except in most carefully selected and exceptional cases. Such exceptions might be the unusually intelligent and cooperative patient, such as a physician, with a minimal pulmonary lesion and microscopically negative sputum, and the pa-

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tient over 70 years of age with a good home in which he can be isolated with a minimal chance of infecting others.

In contrast to the poor results of outpatient treatment of unhospitalized patients, the results of continued drug therapy after discharge from a tuberculosis hospital have been very good.

In general, in hospitalized patients the results of treatment, especially in regard to the incidence of relapse, have improved as the duration of drug therapy has been prolonged. There is now almost general agreement that the minimal average duration of therapy should be at least a year; many are of the opinion that it should be two years and that for some patients with a poor prognosis it should be prolonged indefinitely.[1]

Since it is unnecessary for most patients to remain hospitalized and away from work for such prolonged periods, the obvious answer has been to provide continuation of drug therapy on an outpatient basis. This treatment has been tried on a rather large scale in Detroit, Chicago, Duluth, Seattle and other places with uniformly satisfactory results. Chapman[2] of Detroit reported 2,200 such patients followed for two and a half years after discharge with a relapse rate of 1½ per cent.

Lichtenstein[3] of Chicago reported on a group of 468 patients discharged in a less favorable status than the Detroit group with a relapse rate of 2 per cent in one year. In some cases the relapse was an isolated positive sputum followed by repeated negative findings. These results may be compared to relapse rates of approximately 35 per cent in the same period of follow-up in the years before drug therapy and of 6 per cent or more in patients treated with drugs during the period of hospitalization only.

Drugs Used in Outpatient Therapy

Under ideal conditions any antituberculosis drug or combination of drugs that can be given to hospitalized patients may be used on an outpatient basis. Viomycin and pyrazinamide, however, are sufficiently toxic so that they should be used only when careful and frequent observation and laboratory checks are available. Dihydrostreptomycin produces auditory damage, sometimes progressing to total and permanent deafness, which is apparently related to total dosage, and therefore this drug is not suitable for extremely prolonged therapy. Streptomycin can be used safely for prolonged treatment if arrangements for biweekly intramuscular administration can be made. After long courses, however, many patients experience such symptoms as malaise, headache and drowsiness on the day of injection and sometimes on the following day, which may interfere with work and comfort and demand discontinuance of treatment.[1]

PAS is a difficult medication for many patients to take because of nausea, anorexia, abdominal discomfort and diarrhea. There is no doubt that much of it that has been prescribed, for outpatients especially, has not actually been taken. In Detroit a search of the bushes around the clinic entrance uncovered a great deal of PAS which was never taken home, much less consumed.

Isoniazid is inexpensive and easy to take. Serious toxicity is rare except for hypersensitiveness, which usually develops within two months of starting treatment if it is to occur at all, and for peripheral neuritis which may first appear after prolonged medication. The neuritis usually clears slowly but completely when the drug is discontinued and possibly may be controlled during continued administration by the use of pyridoxine.

The data on the use of isoniazid alone for the continued treatment of patients who have already achieved x-ray stability and sputum conversion are meager and, from the nature of the problem, it will be difficult to establish its effectiveness for this sort of patient as compared to combinations of two drugs since the relapse rate in either group is so small. The results of the studies of Deuschle and his associates,[5] however, and of the United States Public Health Service on the use of isoniazid alone for hospitalized patients and the results of Dressler and his associates[6] on the use of streptomycin and isoniazid for a few months followed by isoniazid alone have convinced many that isoniazid alone is the most practical drug regimen for long continued administration for most discharged patients.

Results in Florida

This type of posthospital outpatient treatment would seem to be useful in Florida. It could be expected to reduce the average period of hospitalization by four months, to reduce the average cost of hospitalization by over $900 and to make it possible each year to hospitalize 639 more of those patients with active tuberculosis who cannot now be cared for in the state tuberculosis hospitals. Such increased isolation and treatment could reasonably be expected to decrease considerably the number of new cases being reported each year.

While a plan to provide posthospital drug therapy can be expected to reduce the average period

of hospitalization from 11 to seven months, this average will, of course, include all discharges such as deaths and discharges against advice. Although the average period of hospitalization for patients discharged with medical advice will be reduced, it is unlikely that it can be brought much below 10 or 12 months.

There is no doubt that a shortened period of hospitalization will increase the follow-up load on the local health departments. The maximum increase in discharges per year from all four state tuberculosis hospitals would be about 639. This increase will not come suddenly. It will begin with a few patients who will be ready for discharge when outpatient drug therapy can be provided and will increase gradually over a period of about a year. The peak load can be expected to continue for one or two years and then gradually to decrease as drug treatment is discontinued for the first patients in the program and as the number of new cases of tuberculosis appearing in the state each year declines.

The increase in follow-up load will not, in fact, ever be quite as large as suggested by the figure of 639 because most of the unhospitalized patients who will be the only source of new admissions are already being followed by their local health departments.

The follow-up work per patient should be no heavier than at present except for the mechanics of procuring and disbursing isoniazid. A patient continuing drug treatment does not require more frequent examination nor more laboratory study than the patient who has discontinued drug treatment. In fact, where posthospital drug therapy has been given on a large scale the work load per patient has been somewhat diminished, except for the mechanics of supplying drugs, because the patient is more likely to return for examination promptly to get his drug supply and therefore the number of home visits by the nursing staff can be reduced.

The load on welfare agencies also may be somewhat reduced since patients can safely return to work earlier if they have the protection of continued drug therapy. Another and unexpected by-product of posthospital drug treatment has been a great reduction in discharges against medical advice. The rate of such discharges declined by approximately 50 per cent in Seattle when drug treatment on an outpatient basis became available.

In one sense the work load and the responsibility of local health departments are considerably increased by this sort of program. From the standpoint of tuberculosis control the chief value of posthospital drug therapy is that it makes hospital beds available for the treatment of more people with active tuberculosis who are spreading the disease in their communities. Since the group of unhospitalized patients is always heavily weighted with the patients who have refused admission or who have left hospitals against advice, it is no easy task for health departments to take full advantage of the extra beds available. While the individual patient and the taxpayer will profit from a shorter period of hospitalization regardless of vacant hospital beds, the general public will profit only in the proportion to which the beds are used to hospitalize others with active tuberculosis.

Since my personal experience during the last six months leads me to believe that the local health departments in Florida are considerably superior to those in most parts of the country, I have no doubt that we can reap the full benefits from such a program if the legislature provides the wherewithal to carry it out. The State Board of Health is asking the legislature for funds to supply drugs for indigent patients discharged from the state tuberculosis hospitals and for funds to assist the local health departments in meeting any increased work load that may result. A committee of the Florida Health Officers' Society is investigating the possibilities and problems of implementing such a program.

I do not know of any area that has actually achieved a satisfactory control of tuberculosis without sufficient beds to hospitalize essentially all patients with active tuberculosis. For Florida more efficient use of our present hospital beds would seem to be the only practical way in which we can reach this goal in the near future. Posthospital continuation of drug treatment would seem to be the most important single improvement we can make to use our hospital facilities more efficiently.

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The Classification and Diagnosis of Mediastinal Tumors

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The mediastinum harbors a wide variety of benign and malignant tumors and cysts as well as certain lesions which may give the clinical appearance of true tumors but are not. It is the purpose of this communication to suggest a classification of these lesions on the basis of location and type, and to discuss methods of diagnosis currently in use.

Little comment will be made concerning therapy except to state that early surgical removal is the procedure of choice in the treatment of practically all primary mediastinal tumors with the exception of the lymphomas. Vascular lesions can often be treated by some form of reconstruction or resection. Bahnson,[1] DeBakey and Cooley[2] and others recently demonstrated the feasibility of surgical resection of aneurysms and replacement with grafts. Anderson,[3] Abbott[4] and others were of the opinion that mediastinal tumors of uncertain diagnosis deserve prompt exploration in order to afford an early, correct diagnosis and to carry out the proper treatment. Exploratory thoracotomy in the modern management of diseases of the chest is no more hazardous in the hands of a competent thoracic surgeon than is laparotomy in the hands of a competent abdominal surgeon.

Classification

As a preface to classification, it would be well to mention briefly the structures lying within the mediastinum and from which primary neoplasms might arise. The mediastinum or intrapleural space is that part of the thoracic cavity formed by the nonapposition of the pleurae extending from the sternum in front to the vertebral column behind and contains all the thoracic viscera except the lungs.[5] Thus, the mediastinum is actually a septum containing some of the most vital organs in the body, and the mediastinal space is more potential than real. In addition, this area serves as a pathway through which important structures pass from the cervical region to the abdomen. Anatomists, for the purposes of description, usually divide it into four parts, the superior, anterior, middle and posterior regions. More practical usage, however, dictates that what is ordinarily referred to as anterior, middle, and part of the superior mediastinum should be grouped together as anterior mediastinum, and similarly the posterior and posterior part of the superior space should be called the posterior mediastinum.[6] The division into anterior mediastinum and posterior mediastinum is designated by an arbitrary, almost vertical coronal plane which corresponds to the anterior wall of the trachea and extends from the superior aperture of the thorax above to the convex surface of the diaphragm below.

Structures normally found within the anterior mediastinum are the thymus gland, lymph nodes, branches of the internal mammary arteries and veins, pericardium enclosing the heart and roots of the great vessels, phrenic nerves, and areolar connective tissue.

The posterior mediastinum contains the thoracic portion of the descending aorta, superior and inferior vena cavae, azygos and hemiazygos veins, esophagus, trachea and main bronchi, thoracic duct, lymph nodes, left recurrent nerve, vagi and their cardiac branches, and branches of the sympathetic trunks. In addition to the structures normally present, the mediastinum, being a midline structure, is occasionally the site of developmental cysts and other anomalies.

It may readily be seen from the preceding comments that all mediastinal tumors, even those histologically benign, are a menace to life, not only because of their tendency to undergo malignant transformation, but because their location allows little room for expansion or growth without encroaching upon vital organs. Although the literature reveals that a high percentage of surgically removed tumors have been benign, Harrington[7] believed that practically all tumors situated within the mediastinum have malignant potentialities.

In 1942, Freedlander[8] proposed the following excellent classification based upon cell type. Considerable progress during recent years in the recognition of lesions of the chest, however, probably makes this classification no longer adequate.

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Tumors of the Mediastinum (Freedlander)

1. Embryologic rests
 - Dermoid-teratoma
 - Aberrant lung tissue
 - Bronchogenic cyst
 - Aberrant lobe
2. Neurogenic tumors
 - Neurofibroma
 - Ganglioneuroma
 - Sympathicoblastoma
3. Connective tissue tumors
 - Lipoma, xanthoma
 - Fibroma, fibromyoma
 - Lymphangioma, hemangioma
 - Sarcoma
4. Primary tumors of lymph nodes
 - Hodgkin's disease
 - Lymphosarcoma
 - Endothelioma
 - Boeck's sarcoid
5. Primary tumor of thymus
6. Carcinoma of mediastinum
 - Primary
 - Secondary
7. Echinococcus cyst
8. Intrathoracic goiter
9. Parathyroid adenoma

Kinsella[9] classified mediastinal tumors according to location and according to benignancy and malignancy. Also included are certain inflammatory masses and other space-constricting lesions which simulate true neoplasms. It is extremely necessary that lesions of this type be recognized inasmuch as they must always be considered in the differential diagnosis of a mediastinal tumor.

Many of the tumors cited as being anterior or posterior in origin may, as a matter of fact, occur either anteriorly or posteriorly, such as the various congenital cysts, chondromatous tumors, fibromas, and so forth; or they may be so large as to extend into both anterior and posterior mediastinum, thus making it extremely difficult to determine the site of origin of the tumor. Indeed, primary nerve tumors, though characteristically occurring in the posterior mediastinum, may occur anteriorly, and likewise the teratoid tumors, usually anterior, may infrequently be observed posteriorly. For purposes of classification, however, reference should be made to the usual location of the tumor.

In an effort to include this variable group of tumors in the classification, Blades[10] divided mediastinal tumors into three categories as follows: (1) tumors which usually originate in the anterior mediastinum; (2) posterior mediastinal tumors; (3) a miscellaneous group of comparatively rare neoplasms which may be located in any part of the mediastinum.

A study by Uhrich[11] of the material available at the Mayo Clinic revealed that 160 primary mediastinal tumors were removed surgically. This series did not include primary and secondary tumors of mediastinal lymph nodes such as lymphosarcoma, Hodkgin's disease and reticulum cell sarcoma, nor did it include metastatic carcinomas, parasitic or hydatid cysts, aneurysms, tuberculous or other granulomatous lesions. Of the 160 tumors, 77 were located in the anterior mediastinum and 83 in the posterior mediastinum. There were 118 benign and 42 malignant tumors (tables 1 and 2).

Table 1.—Benign Mediastinal Tumors (Uhrich)

Type	Cases
Primary nerve tumor	53
Teratoid tumor	29
Mediastinal cyst	18
Fibroma	5
Chondromatous tumor	5
Thyroid adenoma	3
Lipoma	2
Myxoma	1
Hamartoma	1
Parathyroid adenoma	1
	118

Table 2.—Malignant Mediastinal Tumors (Uhrich)

Type		Cases
Thymoma		17
Miscellaneous		7
Diagnostic problems as to whether primary or secondary and as to type		
Final classification		
Fibrosarcoma	4	
Lymphosarcoma	1	
Squamous cell carcinoma	1	
Unclassifiable (undifferentiated)	1	
Chondrosarcomatous tumor		6
Hemangioendothelioma		4
Teratoid tumor		4
Bronchogenic cyst		1
Neurofibrosarcoma		1
Fibrosarcoma in a fibroma		1
Liposarcoma		1
		42

The following summary of cases collected by Uhrich[11] is based upon histopathologic classification and reveals the frequency of occurrence of these lesions in the mediastinum, and also the differential occurrence in anterior and posterior mediastinum in this series (table 3).

The following classification is suggested as a

Table 3. — Mediastinal Tumors: Type and Location (Uhrich)

Type	Total Cases	Per Cent	Anterior Mediastinum Cases	Anterior Mediastinum Per Cent	Posterior Mediastinum Cases	Posterior Mediastinum Per Cent
Primary nerve tumor	54	33.8	3	3.9	51	61.4
Teratoid tumor	33	20.6	28	36.4	5	6.0
Mediastinal cyst	19	11.9	10	12.9	9	10.9
Thymoma	17	10.6	17	22.1	0	—
Chondromatous tumor	11	6.9	4	5.2	7	8.4
Fibroma	6	3.8	2	2.6	4	4.9
Hemangioendothelioma	4	2.5	2	2.6	2	2.4
Lipoma	3	1.9	1	1.3	2	2.4
Thyroid adenoma	3	1.9	2	2.6	1	1.2
Myxoma	1	0.6	0	—	1	1.2
Parathyroid adenoma	1	0.6	1	1.3	0	—
Hamartoma	1	0.6	1	1.3	0	—
Miscellaneous	7	4.4	6	7.8	1	1.2
			—		83	
Total	160		77		83	

working basis for the differentiation of the various mediastinal tumors and other space-occupying abnormalities. It classifies them on the basis of location, benignancy, malignancy and inflammatory masses. An effort has been made to include practically all mediastinal enlargements which might enter into differential diagnosis.

Diagnosis

Diagnosis of a mediastinal mass is usually readily accomplished, but to determine the actual nature and type of the lesion may be extremely difficult and even impossible. The chest roentgenogram, of course, is indispensable and is the most fundamental diagnostic procedure. There are

Mediastinal Tumors

Anterior	Posterior	Variable
A. BENIGN	A. BENIGN	A. BENIGN
Dermoid cyst	Neurogenic tumors	Chondromatous tumors
Teratoma	Neurofibroma	Chondroma
Substernal or intrathoracic thyroid	Ganglioneuroma	Chondromyxoma, etc.
Thymoma	Xanthoma (?)	Hamartoma
Bronchogenic cyst	Congenital cysts	Lipoma
Pericardial celomic (spring water) cyst	Esophageal	Fibroma
Cystic hygroma (lymphangioma)	Gastroenterogenous	Hemangioma
	Bronchial	Parathyroid adenoma
	Cystic azygos or accessory lobe	
	Leiomyoma or lipoma of esophagus	
B. MALIGNANT	B. MALIGNANT	B. MALIGNANT
Malignant teratoma	Neurofibrosarcoma	Primary carcinoma of mediastinum
Lymphoblastomas	Sympathicoblastoma	Sarcoma (fibro, lympho, chondro, etc.)
Hodgkin's disease	Carcinoma of esophagus	Hemangioendothelioma
Lymphosarcoma	Tracheal tumors	Metastatic tumors
Reticulum cell sarcoma		
Malignant thymoma		
Lymphatic leukemia		
C. INFLAMMATORY MASSES	C. INFLAMMATORY MASSES	C. INFLAMMATORY MASSES
Aneurysm	Paravertebral abscess (including Pott's disease)	Mediastinal abscess
Aortic		Tuberculoma
Innominate		Enlarged lymph nodes
Pulmonary		Tuberculous
Patent ductus arteriosus		Silicosis
		Boeck's sarcoid
		Echinococcus cyst
		Nonspecific granuloma
D. PSEUDOTUMORS	D. PSEUDOTUMORS	D. PSEUDOTUMORS
Diaphragmatic hernia (foramen of Morgagni)	Ectasia of esophagus (secondary to cardiospasm)	
	Esophageal diverticulum	
	Paraesophageal hiatal hernia	

numerous other symptoms and tests, however, which are important in the diagnosis. A mediastinal tumor may be entirely silent and be discovered only during the course of a routine physical examination. This fact was emphasized by Blades[12] in a paper dealing with mediastinal tumors treated at the various United States Army Thoracic Surgery Centers. When mediastinal tumors give rise to symptoms, they may be grouped into three categories, namely, general, local and specific. Any tumor may give manifestations of one or of all types of symptoms.

General Symptoms. — By general symptoms is meant those symptoms common to any tumor of the mediastinum, such as pain in the chest, dyspnea, wheezing, cough and cyanosis. They are usually the result of mediastinal compression, and vary with the size and location of the lesion and degree of pressure exerted on the various mediastinal structures. Anterior tumors are more prone to cause pain than are posterior tumors because of greater limitation of space in the anterior mediastinum, the tumor therefore creating its own space by pressure on the surrounding structures. The pain is substernal or interscapular as a rule, or may radiate to the shoulders and arms. The type of pain is variable, being dull and aching in character, pleuritic, or boring as in aneurysms; or it may be merely a sensation of substernal oppression. Dyspnea and wheezing are usually of the type associated with bronchial or tracheal obstruction. The cough is the result of tracheal or bronchial irritation due to pressure and may or may not be productive of mucoid sputum. Cyanosis may be limited to the head and thorax and may be associated with edema and venous engorgement of the upper extremities and head. Rarely, osteoarthropathy has been noted as the first sign of a mediastinal tumor. Generalized symptoms such as weakness, anorexia, loss of weight, anemia and fever may be encountered in malignant lesions in the mediastinum as well as elsewhere in the body. These occur less frequently, however, because the strategic location of the tumor usually causes it to become manifest before these late signs and symptoms develop.

Local Symptoms. — The local symptoms and signs of a mediastinal tumor are those which are the result of involvement of structures in the immediate neighborhood of the lesion, or which may be visible through local swellings, pulsations or other manifestations. Among these may be included visible swelling over the chest or in the suprasternal region with or without associated pulsation; dilatation of the veins of the neck and chest indicating pressure on the superior vena cava and sometimes associated with edema of the face; inequality of the pupils or a definite Horner's syndrome; hoarseness due to pressure or invasion of the recurrent laryngeal nerve; dysphagia due to pressure upon or displacement of the esophagus; and herpes or neuralgia resulting from intercostal nerve involvement. Some of these have a definite localizing value, as, for example, Horner's syndrome, which indicates a posterior superior mediastinal lesion involving the paravertebral sympathetic chain. Another example is the hourglass or dumbbell type of neurofibroma, which gives rise to spinal cord symptoms.

Specific Symptoms. — By specific symptoms or signs is meant any manifestation which suggests a specific lesion, as, for example, the weakness dysphagia and other features of myasthenia gravis which may be associated with a thymoma. Another example would be the expectoration of hair in the case of a teratoid tumor which had eroded through a bronchus. Substernal goiters practically always have associated thyroid enlargement in the neck or a scar from previous thyroidectomy.



Fig. 1. — Pericardial cyst.

Physical Examination. — Physical examination may give entirely negative results, or there may be asymmetry of the chest, widening of the mediastinal dulness, or bulging of the sternum in advanced cases. Infection within the tumor and bronchial or pleural communication may serve to confuse the picture and make accurate diagnosis more difficult. Even the chest roentgenogram is not completely reliable inasmuch as one cannot al-

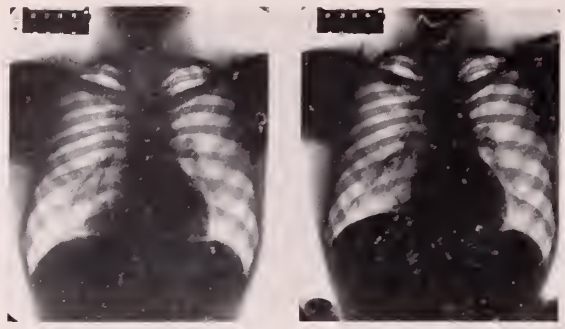


Fig. 2. — Gastroenterogenous cyst. Left: Preoperative roentgenogram. Right: Postoperative roentgenogram.

ways be certain whether a given lesion is within the lung or in the mediastinum.

DIFFERENTIAL DIAGNOSIS. — In addition to the signs, symptoms and physical examination, the diagnosis and differential diagnosis of a mediastinal tumor often will require all the resources of the internist, roentgenologist, bronchoscopist and thoracic surgeon. Additional procedures which may be employed for this purpose include bronchoscopy, fluoroscopy and special roentgenographic studies such as Bucky, oblique and lateral films, laminography, diagnostic pneumothorax with or without thoracoscopy, and pneumoperitoneum.



Fig. 3. — Gastroenterogenous cyst. Specimen opened showing cyst lined with gastric mucosa.

Supraclavicular and scalene node biopsies are of value. Angiocardiography is used in cases of suspected aneurysms and cardiovascular lesions.

The response to a therapeutic trial of roentgen therapy has long been used as a diagnostic procedure in the case of possible lymphoblastoma. It is the opinion of some authorities, however, that this procedure is no longer sound and has been greatly misused in the past. Abbott[4] stated that only too frequently it has been his experience to find an operable lesion which has undergone roentgen therapy to no real purpose other than to increase the difficulties of the operative procedure. Certainly, no lesion of the mediastinum which is smooth in contour should be subjected to this approach. Certain lesions of the mediastinum may be sensitive to roentgen therapy and yet be better treated by resection. Classic examples are malignant tumors of the thymus, substernal thyroid, and malignant teratoma.

Aspiration biopsy of tumors near the wall of the chest has been recommended by some authors and frowned upon by others. Esophagoscopy and barium studies should be carried out in the case of suspected esophageal lesions and diaphragmatic hernias. Tracer doses of radioactive iodine have

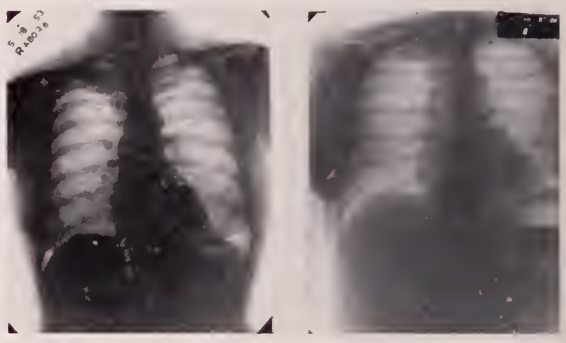


Fig. 4. — Benign lipoma originating in the superior mediastinum and extending into cupola of right thorax. Left: Posteroanterior roentgenogram. Right: Lordotic roentgenogram.

been employed in the diagnosis of intrathoracic goiters.[13] This procedure has also been used in attempting to identify metastasis from thyroid carcinoma. The blood picture may assume diagnostic significance, an example being the eosinophilia associated with parasitic cysts. The intradermal test of Casoni gives positive results in such a high percentage of cases of echinococcus cyst as to be practically diagnostic. Craig and Faust[14] stated: "Injection of 0.2 cc. of sterile, unpreserved hydatid fluid into the skin produces a wheal up to 5 cm. in diameter with pseudopodia in about twenty minutes in all positive cases, with no false positives."



Fig. 5. — Benign lipoma of superior mediastinum. Multilobular specimen following excision.



Fig. 6. — Substernal thyroid causing pronounced stridor as a result of tracheal compression. Left: Posteroanterior roentgenogram. Right: Oblique roentgenogram.

Blood serology may be helpful in ruling in or out an aneurysm although aneurysms of arteriosclerotic origin are probably more common than was previously thought to be the case. Expansile pulsation on fluoroscopy has long been the classical sign of an aortic aneurysm. Diagnosticians have come to realize, however, that this may be misleading at times, being absent in some cases of aneurysm and apparently present in various tumors and cysts. Furthermore, the accurate differentiation between expansile and transmitted pulsation is not always easy, even for the experienced radiologist.



Fig. 7. — Substernal thyroid. Specimen removed through cervical approach.

Despite the employment of all of the present diagnostic methods, experience has shown that only too often one has succeeded in establishing the presence and location of a mediastinal tumor, but has been unable to determine its exact pathologic nature. When this situation exists, the physician must endeavor to bring into play the nicer refinements of diagnostic technic, in this instance with respect to the variation in the roentgenographic shadows cast by the different mediastinal tumors and also as regards the predilection of certain tumors for certain locations in the mediastinum as indicated in the previously outlined classification. Although neither of these criteria can be considered as infallible, they frequently enable one to differentiate a lesion amenable to surgical removal from an inoperable malignant growth, for example. The surgeon should also know the relative frequency of occurrence of the commoner tumors. According to McDonald,[15] the commonest surgically removed tumor of the mediastinum in cases seen at the Mayo Clinic is the neurofibroma or primary nerve tumor comprising about 30 per cent of all such neoplasms. This of course does not include the lymphoblastomas or aneurysms which are possibly more common. Teratomas and dermoid cysts equally divided make up about 20 per cent of the entire group. Neurofibromas are the most frequently observed tumor of the posterior mediastinum whereas the teratoid group are the commonest anterior tumor. These figures are substantiated by the work of Uhrich.[11] The experience of various other authors, notably Kinsella[9] and Heuer and Andrus,[16] indicates that the teratoma-dermoid group occur more frequently than do the primary nerve tumors. It is variously estimated that 10 to 20 per cent of teratomatous tumors are malignant.

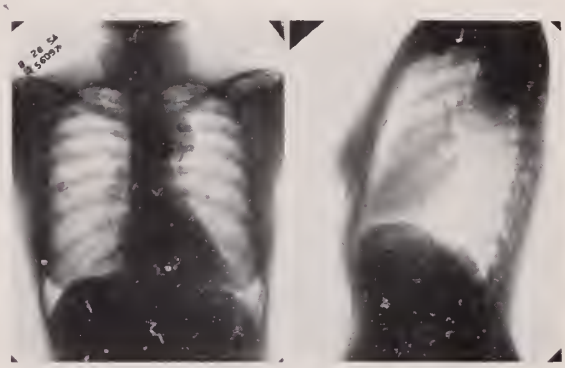


Fig. 8. — Neurofibroma. Left: Posteroanterior roentgenogram. Right: Lateral roentgenogram illustrating usual posterior location of this tumor.

The roentgenogram should be closely studied. Lateral and oblique views are indispensable. Well

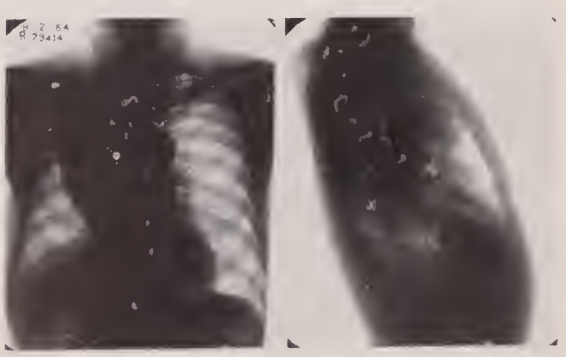


Fig. 9. — Malignant schwannoma (neurilemma), unresectable. Left: Posteroanterior roentgenogram. Right: Lateral roentgenogram.

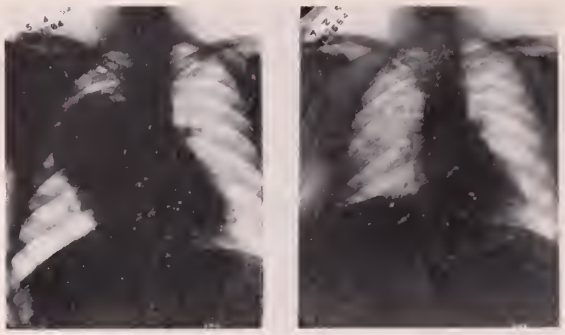


Fig. 10.—Teratoma. Left: Preoperative roentgenogram. Right: Post-operative roentgenogram.

circumscribed shadows in the mediastinum are apt to be benign and operable whereas the diffuse, irregular, poorly defined shadow is most often indicative of a malignant lesion. The presence of calcium in the wall or bony spicules suggests a teratoid tumor, and the roentgen visualization of a tooth within the mass is diagnostic.

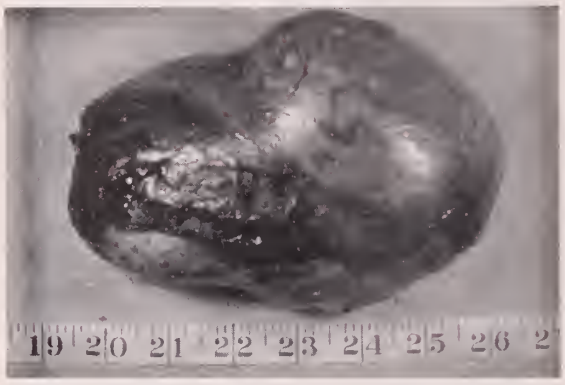


Fig. 11.—Terotoma. Operative specimen.

Lipomas are not as dense radiographically as some of the more solid tumors and there is said to be a peripheral zone of increased radiability. These tumors may attain huge proportions and comprise some of the largest intrathoracic tumors.

An occasional posterior tumor will prove to be a dumbbell neurofibroma with intraspinal extension of the tumor through the lateral foramen. In such cases the roentgen studies may reveal pressure erosion of the vertebral pedicles or intervertebral foramina. In addition, mediastinal neurofibromas may be associated with a generalized von Recklinghausen's neurofibromatosis, a valuable diagnostic aid when present.

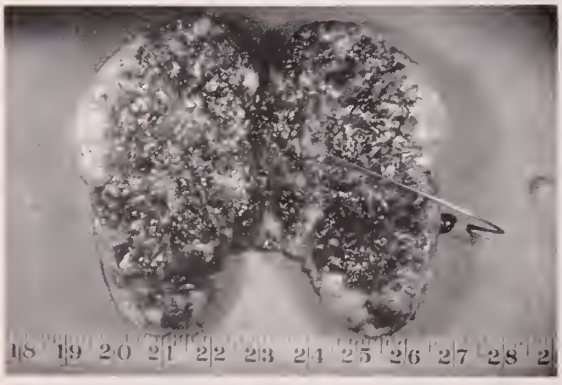


Fig. 12. — Teratoma. Operative specimen opened. Pointer demonstrates bone formation within tumor.

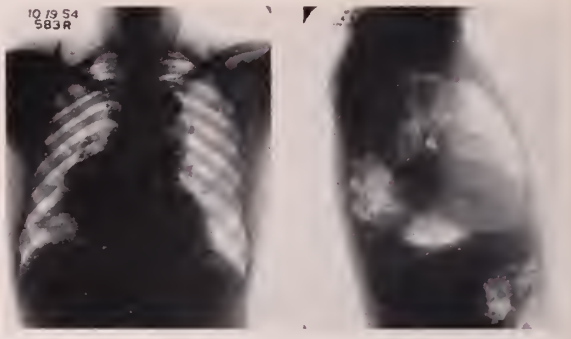


Fig. 13. — Aneurysm of descending aorta presenting in right thorax and simulating mediastinal tumor. These lesions characteristically present on the left. Treated by Bahnson's method of excision of sac and aortic suture. Left: Posteroanterior roentgenogram. Right: Lateral roentgenogram.

Thymomas are practically all potentially malignant, and 5 to 10 per cent will have metastasized when found. In a series of 191 consecutive cases of myasthenia gravis studied by Clagett and Eaton,[17] a definite roentgenologic diagnosis of thymic tumor was made in 30 cases, an incidence of 15.7 per cent. Conversely, Murray and McDonald[18] concluded that the incidence of myasthenia gravis among patients suffering from thymoma is nearly 100 per cent.

According to Cope,[19] in a series of 60 cases of hyperparathyroidism, 54 being adenoma and 6 hyperplasia of the parathyroid gland, 18 per cent of the glands were discovered in the mediastinum, 10 per cent anteriorly and 8 per cent posteriorly. They are usually small and not visualized by means of roentgenography. In any case of hyperparathyroidism, however, when glands cannot be found in

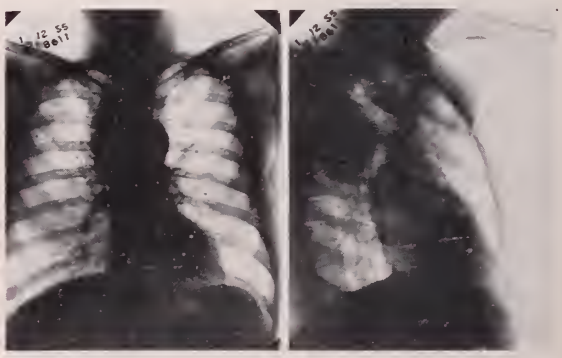


Fig. 14. — Bronchogenic carcinoma originating in medial aspect of right upper lobe and simulating mediastinal tumor. Left: Posteroanterior roentgenogram. Right: Oblique roentgenogram.

the neck, exploratory mediastinotomy should be performed.

Nearly 30 per cent of patients with Hodgkin's disease complain of skin irritation and pruritis or urticaria at some time. A few will have intrabronchial or intrapulmonary extension of the lesion, rarely with bronchial obstruction.

Despite all that has been said regarding methods of diagnosis, certain lesions may become so large as to defy any attempt to determine the exact site of origin, and there is also the group of tumors which may arise either anteriorly or posteriorly. Even teratomas and neurofibromas do not invariably occur where one anticipates them



Fig. 15. — Pronounced swelling of trunk, head, neck and upper extremities resulting from superior vena caval obstruction by mediastinal malignant disease.

to be. It must be admitted therefore, in the final analysis, that there are still diagnostic limitations in the way of arriving at the final evaluation of certain mediastinal tumors, and in these cases the benefit of exploratory thoractomy or mediastinotomy should not be withheld.

Summary

A classification of mediastinal tumors is presented which is based on the location and type of the tumor as well as on benignancy, malignancy, inflammatory masses and pseudotumors. Problems encountered in the differential diagnosis of these lesions are discussed. In the great majority of instances exploratory thoracotomy or mediastinotomy will be required for accurate diagnosis and proper treatment, and procrastination is not warranted.

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Discussion

Dr. DeWitt C. Daughtry, Miami: I wish to congratulate Dr. Seiler on being able to cover such a broad subject in such a short presentation. He has certainly given an excellent general discussion of this broad field of mediastinal tumors. In the past 10 years much emphasis has been placed upon the management and diagnosis of mediastinal lesions because of the use of mass x-ray surveys and the extensive use of roentgen studies in the examination or investigation of sick and well people. Many of these lesions are asymptomatic, but nevertheless are dangerous and often fatal or potentially fatal. In 120 personal cases, the commonest ones encountered were substernal thyroid, thymomas, those of neurogenic origin, and a large group of paramediastinal tumors. Most of them have been of the pleuropericardial (celomic) cyst type.

Diagnosis, or an approximate diagnosis, can be made in the majority of cases. Information can usually be obtained to differentiate between medical and surgical lesions. The majority of the lesions are certainly surgical. The management as a rule is not difficult, but an occasional case may prove exceedingly difficult to manage. Prognosis is good in the benign group of mediastinal tumors if they are properly diagnosed and managed. The prognosis, however, is poor for the malignant lesions and also for those which are not properly managed and are allowed to go on to severe complications.

As a rule roentgen therapy is contraindicated and may deny the patient a cure. Prolonged observation constitutes improper management in my estimation. This slide shows a rather unusual mediastinal lesion of the cervical-mediastinal hygroma or lymphoma type. The cervical component has been injected with a little lipiodol and it gravitated into the anterior mediastinum. After aspiration of about 500 cc. of fluid from the neck, we see considerable decrease in size as shown on this slide.

The second patient allegedly had a total thyroidectomy through the neck approach several years ago. She came in with dyspnea and wheezing. X-ray revealed what appeared to be an anterior and posterior mediastinal tumor

with the trachea compressed between the two. It is well represented on this slide. Radioactive iodine tracer study proved at least one of the tumors to be thyroid tissue. At surgery the anterior tumor proved to be ectopic thyroid tissue and obtained its blood supply directly from the arch of the aorta. The tumor posterior to the trachea was thyroid tissue (colloid goiter) connected with the neck structures by a small isthmus of thyroid tissue. I believe this is a very usual case.

I would like to re-emphasize that unless a mediastinal lesion is fairly conclusively proven to be lymphomatous or metastatic in origin that it should be biopsied before x-ray therapy is given or a decision is made to treat the condition by other nonsurgical measures.

DR. LAWRENCE H. KINGSBURY, Orlando: A review of the literature covering the past 10 years is impressive for the ever increasing frequency of the discovery of these tumors and also for the unanimity of agreement as to the treatment. Points I should like to make have to do with the differential diagnosis and secondly with surgical treatment. Sosman in 1927 and Osler Abbott in 1948 pointed out the value of angiography and venography in the diagnosis of these masses. I would stress the ever increasing scale of the use of these methods in vascular disease and emphasize the fact that the nature of the mass in the mediastinum can be defined considerably and therefore coped with more advantageously if the operative diagnosis is as exact as possible. It goes without saying that adequate and complete additional studies including skin tests are of great use. It should be stressed secondly that the new drug Dionosil as a contrast medium for bronchial studies, so far as I have been able to determine from the use of this material in 258 cases, leaves no undesirable residuals and has caused no iodine reactions. Its use in the study of thoracic problems, mediastinal or otherwise, is justifiable on an ever increasing scale. Radioactive iodine has already been mentioned.

Regarding the surgical treatment, first, in reviewing the literature it is apparent that mass survey mechanisms, as has been mentioned, bring to light an increasing number of these tumors. Since there are varieties of mediastinal masses such as those of embryonic origin, deriving from the gastrointestinal tract, which do not permit an expectancy beyond the age of 40 as a rule, should one not advocate the extension of photofluorographic screening to include the newborn? Pate, Gross and Crawford and others have shown that these infants tolerate surgery reasonably well. It seems reasonable, therefore, to assume that deaths in the newborn often attributed to other causes may be in reality due to mediastinal masses undiscovered.

Second, I would emphasize the time for surgery. We all agree that the treatment is surgical, and I do not believe that anyone here would fail to send a patient with a silent mediastinal mass to the surgeon. Yet the majority of patients now operated on have symptoms referable to compression of adjacent structures. What otherwise might have been a relatively safe or even a simple operation in many instances is often hazardous and even a heroic effort to save a life.

The final point I would make relating to surgical intervention has been brought out somewhat before. A review of 264 cases recorded in the literature indicates that in an estimated 16 per cent actual malignant areas are discernible microscopically. The malignant change is not necessarily toward distant metastases, but the cell structures and also the tendency to local extension are often present.

DR. FRANCIS N. COOKE, Miami: I have enjoyed Dr. Seiler's presentation and I should like to take a moment to demonstrate one point in diagnosis that I think might be important. To paraphrase an old saying that all that glitters is not gold, all shadows seen within the mediastinum are certainly not tumors. I am sure Dr. Seiler did not imply such, but I will show a few slides to demonstrate what I have in mind. This slide shows a mass above the right diaphragm in a patient in the 20 to 30 year age group — this slide shows the mass on the lateral film to be anterior. The tumor was removed and was a pericardial coelomic cyst, a clear-water cyst so-called. Here is another patient, same age group, and the x-ray findings are almost identical. The lateral film shows a mass in the same area. This proved to be another pericardial celomic cyst. In a third patient, the same age, the mass is seen here just above the right diaphragm. The lateral view shows the mass in the same area as in the preceding patients. This patient, however, had amebas in his stools. Because of their presence, a pneumoperitoneum was performed, as seen on this slide. I think that you can see the mass; it is well above the abdominal viscera. Both leaves of the diaphragm are here well outlined. There is no apparent connection between this mass and the liver as would be expected, were this an amebic abscess. Nevertheless, because of the amebas in the stools this patient was given a course of emetine, and the mass disappeared. Here is a lateral film, post treatment, showing nothing but the residuals of what presumably was an inflammatory process due to the Entomoeba histolytica, despite the fact that the x-ray findings were almost identical with those of pericardial celomic cysts and also despite the fact that pneumoperitoneum demonstrated the under surface of the diaphragm free of any obvious connection with the liver.

Members of the Florida Medical Association interested in presenting scientific papers at the 1956 annual meeting of the Association should contact Dr. Donald F. Marion, chairman, Scientific Work Committee, P.O. Box 1018, Jacksonville.

Report on an Epidemic of Infectious Hepatitis

Charles H. Carter, M.D.
GAINESVILLE

In an epidemic of infectious hepatitis at the Florida Farm Colony, the medical staff attempted to prevent the occurrence of hepatitis by producing a passive immunity. Dr. M. E. Drake of Vineland, a New Jersey institution, found in an epidemic there that 0.01 cc. of gamma globulin per pound of body weight was as effective as the 0.02 cc. per pound usually recommended and used in our test. He also found that the administration of 0.005 cc. of gamma globulin per pound of body weight permitted many patients in an institution to have a relatively harmless anicteric form of the disease and to gain active immunity. This amount protected patients for many months.

Progress of Epidemic

On Jan. 29, 1954 a patient in ward 1 returned to the institution from a three weeks' vacation. Eleven days later there developed signs and symptoms of infectious hepatitis. He was hospitalized, isolated and treated for this condition. Twelve days later, 2 other patients from ward 1 were admitted to the hospital with the same condition.

At this time we discussed this condition with Dr. Frank M. Hall, Alachua County Health Officer. He recommended giving Red Cross gamma globulin to the patients in the affected ward and isolating this group. The ward was isolated at once, as completely as possible, and the gamma globulin was given upon arrival six days later, February 26.

By this time 3 patients had been admitted from wards 2 and 3. These wards were isolated at once. In these cases the disease evidently was spread by personal contact as there was little chance of the fecal-oral type of transmission. There was sufficient medication present for treatment of the patients in two wards; so these were treated at the level of 0.02 cc. per pound of body weight. There were no further cases on either ward until two and a half and four months later, and these were light. There may have been other cases, but they were either anicteric or light. The limited laboratory staff was too busy for routine tests on patients in these wards.

Read before the Florida Health Officers' Society, Tenth Annual Meeting, St. Petersburg, April 4, 1955

On March 8, 2 patients were admitted from ward 4, which was isolated at once, and the patients were treated with gamma globulin on the following day. There were no other apparent cases on this ward until May 30 when 1 patient had a light form of the disease.

On April 10, the disease developed in a girl living on ward 5 and working on ward 6; so the patients in both wards were treated with gamma globulin. No further apparent cases appeared on either ward.

On April 20 ward 7 became involved, with 5 cases of visible hepatitis occurring in eight days. The gamma globulin was given on April 27, and two days later 1 patient had a light form of the disease. No other cases occurred on this ward.

The next ward involved was ward 8, the home of a boy who worked on a ward previously discussed. Hepatitis developed in this boy on April 20, and he was isolated immediately, as were the two wards. Gamma globulin was not available at once as these were all grown men, who required large doses of medication. The next case occurred on April 28, and the serum was given May 1. Cases followed at almost five day intervals for the next 25 days. The gamma globulin was then repeated, and there were no further cases.

On April 25, 1 case occurred in ward 9. Gamma globulin was given, and other light cases occurred two and four weeks later. In ward 10 there was 1 severe case on April 21. Serum was given at once, and one light case occurred three weeks later.

On May 5 there was 1 case in ward 11, and serum was given on May 13. There were 2 other cases in two and three weeks, but these were light.

A case occurred in ward 12 on May 7, and serum was given on May 11. Other cases occurred on May 17, 18 and 26. These were all older patients. There was a case on May 10 in ward 13. As this was a large ward of older men, serum was not given until May 20 when enough could be obtained. One additional case occurred the next day. There were 4 other scattered cases occurring later.

On May 20, after conferences with Dr. Hall and Dr. Lorenzo L. Parks, Director of the Bureau

of Preventable Diseases, Florida State Board of Health, it was decided that no progress could be made by treating individual wards. Enough gamma globulin was allotted to treat the entire population of patients and attendants. This was done on June 2. There were 3 apparent cases of hepatitis afterward, all within seven days, and all light.

Treatment

During the entire epidemic there were 61 cases of diagnosed hepatitis out of a population of almost 1,000 people. There were no fatalities. The average time in bed was 24 days. Treatment consisted of intravenous administration of a 10 per cent solution of glucose in saline in large amounts, high carbohydrate-low fat intake, and choline in the form of Methischol. This was given by hypodermic when nausea prevented oral use; magnesium sulfate was given daily. Patients were given alternately by admission, penicillin, Aureomycin and Terramycin. No significant difference could be noted in the response to any drug.

An icteric index was run monthly on each patient until the value returned to and remained normal. The choline has been continued until the present time. Two patients still have a significantly increased icteric index. Cephalin-cholesterol flocculation tests were made on March 24, 1955 on all patients. The results were negative in 7, 1 plus in 13, 2 plus in 6, 3 plus in 31, and 4 plus in 1 in 48 hours.

Summary

An epidemic of hepatitis occurred in the Florida Farm Colony, beginning on Feb. 8, 1954. An attempt was made at control by treating the patients on each ward with gamma globulin in the recommended dose, and isolation of each ward. The integrated and interdependent life of the institution made isolation impossible, and by the personal contact routes, the disease spread until three months later there were 58 cases. The entire population of the institution was treated, and the result was a dramatic cessation of new cases.

Treatment in all cases was given as completely as possible, and no fatalities occurred. No effect was observed from an antibiotic. Some liver damage has persisted in most cases, and is severe in a few cases.

Florida Farm Colony.

Emphysematous Cholecystitis

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More than half a century has elapsed since gas in the gallbladder was first described. The paucity of reported cases of emphysematous cholecystitis, however, suggests that this disease is perhaps not infrequently unrecognized. This infection of the gallbladder is caused by gas-forming bacteria and is characterized by air within the lumen, often with infiltration of air into the wall and the pericholecystic tissues. Emphysematous cholecystitis is the commonly accepted term for this clinical entity, but it is also known by other designations such as acute pneumocholecystitis, cholecystitis emphysematosa, acute gaseous cholecystitis and pyopneumocholecystitis. Gas gangrene of the gallbladder, the term used by some authors, carries the connotation of association with Clostridium welchii, which is not the causative organism in all cases of gas in the gallbladder; and in some cases of acute cholecystitis, in which Cl. welchii is present in pure culture, gas is not found.[1]

Stolz,[2] in 1901, first reported finding gas in the gallbladder and biliary ducts at autopsy in 3 cases, but regarded this phenomenon as a postoperative development. Seven years later, Lobinger[3] reported the presence of gas in the gallbladder of a patient undergoing cholecystectomy for acute cholecystitis. Since his report in 1908, sporadic cases of emphysematous cholecystitis have been reported in the world literature, the early ones numbering only 2 in the 1920s and 4 in the 1930s. In 1951, Qvist[4] reported 24 collected cases and added 1 of his own. The tabulation of Bell, Brown and Lenhardt[5] in 1953 included 27 cases, 2 of which were their own, but omitted the case of Qvist[1] and 1 other[6] in his list. Also omitted were 1 case of Gowdey and

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Copeland,[7] reported in 1950, 1 case of Retterbush, Fishman, Baird and Collins,[8] reported in 1951, 2 cases of Kent,[9] reported in 1951, and 1 case of Mooney and Matzinger,[10] reported in 1952. The reported cases, therefore, apparently now number 34, and the case herein reported becomes the thirty-fifth. The ages in these 35 cases ranged from 32 to 75, averaging 58.5 years. There were 28 men and 7 women, a ratio of 4 to 1. The preponderance of cases in men is particularly noteworthy in view of the reported higher incidence of acute cholecystitis in women.[8] Also of interest is the incidence of diabetes in various grades of severity in 8, or 40 per cent, of the 20 cases in which there is record of urine and blood sugar determinations. Although cholecystitis occurs with some frequency in patients with diabetes, this percentage appears excessive.

The various bacteria regarded as causing emphysematous cholecystitis include Cl. welchii, Escherichia coli, both aerobic and anaerobic streptococci, and also staphylococci. In our case Staphylococcus aureus was the offending organism. The views of the different authors on the pathogenesis of this disease were adequately reviewed recently by Bell, Brown and Lenhardt,[5] and earlier by Kent.[9]

At operation in most reported cases, the pathologic findings consisted of a tense, distended gallbladder and discoloration of varying degree. In most cases there was gas within the lumen of the gallbladder with foul-smelling exudate of bubbling character. Often, the mucosa was gangrenous and completely separated from the muscularis, this separation affording an explanation for roentgen delineation of the gallbladder shadow as a concentric ring of lesser density representing the layer of gas between the mucosa and the muscularis. Biliary calculi were frequently present. Because of the gas within it, the thickened wall of the gallbladder was crepitant, and multiple adhesions between the omentum and the adjacent viscera added to the difficulties of the operative procedure.[1]

Clinical Picture

In most respects the clinical picture in the reported cases resembled that of acute cholecystitis not characterized by the presence of gas in the gallbladder. Pain of abrupt onset was as a rule the chief complaint. Initially it was epigastric, but later became localized in the right upper quadrant of the abdomen; at times, it radiated to the back or shoulders. Nausea was commonly present, and vomiting, which occurred in half of the cases, was sometimes the first indication of the disease. Frequently, however, previous attacks of biliary colic or previous episodes of gallbladder disease had occurred. Such attacks had occurred in our case over a period of 30 years. In approximately one fourth of the cases there was a history of jaundice,[5] and frequently encountered was a history of chronic eructation, fulness and constipation.

The patient usually appeared acutely ill even though there often was only slight elevation of temperature. Although the temperature varied from 97 to 103 F., it most frequently ranged from 99 to 102 F.[1] Aside from one early elevation to 100 F. rectally in our case, the patient remained afebrile. The pulse rate varied with the temperature, ranging from 84 to 110. Tenderness and rigidity in the right upper quadrant of the abdomen were characteristic, and in about half of the cases a mass could be palpated. The leukocyte count varied from 10,000 to 30,000, and there was an increase in neutrophils and band forms.

Roentgen Diagnosis

Since emphysematous cholecystitis is indistinguishable clinically from acute cholecystitis without gas formation and even at operation may not readily be recognized, this entity takes on added importance roentgenologically. Preoperative diagnosis is dependent upon the demonstration by cholecystographic examination of gas in the gallbladder or in its wall and in the pericholecystic tissues. Hegner,[11] in 1931, by recognizing the characteristic roentgen findings in this disease, was the first to make a preoperative diagnosis.

Although in emphysematous cholecystitis the presence of gas may be demonstrated at any time after the onset of the initial symptoms,[1] frequently no gas is visible in the first 24 to 48 hours.[1] Then a gas shadow appears at the site of the usually enlarged gallbladder, as well demonstrated by serial cholecystograms in the cases of McCorkle and Fong.[12] A fluid level may be demonstrated at this time by a cholecystogram taken with the patient in the upright position. Later, there appears a darker, concentric annular shadow of lesser gaseous density indicating gas in the wall of the gallbladder. Usually it involves the fundus and often it extends completely around the viscus. At this stage gas may still be present within the lumen. In a later stage, as demonstrated in the cases of Friedman, Aurelius and

Rigler,[1] the gas is apparently absorbed within the lumen, for the concentric, smooth, clearly demarcated ring surrounding the gallbladder becomes streaked and bubble-like in appearance, indicating a mixture of fluid and gas within a limiting membrane. Thus the vacuolized shadow establishes the presence of gas bubbles in the surrounding tissues and offers evidence of pericholecystitis. The process may spread into the common duct and into the biliary ducts, causing cholangitis to be present also, but the biliary tract is not as a rule distended with gas.[1,4] If there is recovery without surgical intervention, the gas gradually subsides, and the size of the gallbladder shadow decreases correspondingly. Even after clinical cure, however, small amounts of the gas may persist.[4,12]

Differential diagnosis requires exclusion of the presence of an internal biliary fistula or an incompetent sphincter of Oddi, through which gas may enter the gallbladder or the common duct. A complete examination of the gastrointestinal tract, including a barium enema study, will usually rule out those avenues of entry. In such cases the gallbladder is generally of normal size, and roentgen studies show neither an annular shadow nor gas bubbles in the pericholecystic tissues. The roentgenologic appearance of lipomatosis of the gallbladder wall may simulate that of emphysematous cholecystitis. The annular shadow, however, does not change configuration, as gas shadows may do, with change in position of the patient, nor is there change from day to day or at shorter intervals in the roentgen picture. Also, there is no gas-fluid level.[5]

Calculi are not necessarily a part of the picture. Some authors were of the opinion that in this disease the cystic duct is blocked by a stone, but in a number of cases no stone was found in the gallbladder. In our case stones were found in the common duct.

The roentgenologic evidence of emphysematous cholecystitis is highly typical and may be considered pathognomonic either when the gas is present within the gallbladder cavity or in its wall or in the pericholecystic tissues. Cholecystographic studies offer the one means of preoperative diagnosis.

Treatment

The diversity of opinion regarding treatment is reflected in the therapeutic measures employed, which have varied from conservative medical management to radical surgery. Sulfonamides, antibiotics, polyvalent vaccine and roentgen therapy alone, or in combination with cholecystectomy or cholecystostomy, have all been employed, as well as mere bed rest and supportive treatment.

Heifetz and Senturia,[13] for example, favored surgical therapy only, in view of the increased tension on the wall of the gallbladder when gas is present with consequent greater risk of gangrene and perforation. They regarded cholecystectomy, particularly in the first stages of inflammation, as the procedure of choice. Jemerin[14] also advocated cholecystectomy, either in the acute stage or in a symptom-free interval, depending upon local findings and the general condition of the patient. Preferring immediate surgical intervention with cholecystectomy, if possible, Retterbush, Fishman, Baird and Collins[8] were impatient of delay, noting that the average length of time from hospitalization to operation was 9 days in the 21 cases which came to their attention. They cited cases to illustrate that "a frequent manifestation of conservative therapy is a dissemination of the infection rather than a quiescence of the disease." Likewise, Bell, Brown and Lenhardt[5] advocated surgical intervention, combined with chemotherapy, for this severe and spreading infection, concluding that "basic surgical principles are not being satisfied when one assumes a *laissez-faire* attitude toward its surgical treatment."

On the other hand, McCorkle and Fong[12] recommended conservative therapy, which they employed in 2 of 3 cases after the first case terminated fatally following operation. In the first case reported by Friedman, Aurelius and Rigler[1] cholecystectomy was performed, and in the other 3, treatment was conservative, with recovery in all 4.

Of the 35 cases reported in the literature, including the present case, cholecystectomy was performed in 15 and cholecystostomy in 9. Conservative treatment was employed successfully in the remaining 11 cases. Three of the 4 surgical cases terminating fatally occurred prior to the advent of antibiotics, with pulmonary embolus the cause in Hegner's case, and death ensuing in the fourth case following a cerebral accident 24 days postoperatively.

Report of Case

A 67 year old white janitor was admitted to St. Luke's Hospital on Feb. 28, 1954, complaining of severe pain in the epigastrium and the right upper quadrant of the abdomen, which had been present since the previous evening. The pain was aching and constant in character with inter-





Figs. 1 and 2.—Cholecystograms made at a prior examination on Sept. 21, 1953, six months before the present admission, were incorrectly interpreted as giving negative evidence. The radiolucent shadow surrounding the gallbladder cavity represents an emphysematous cholecystitis.

mittent exacerbations and radiated to the back. It was associated with frequent episodes of vomiting and the vomitus contained some bile. There had been no change in the bowel habits nor in the color of the stools or of the urine.

For 30 years the patient had experienced numerous similar episodes, which necessitated hospitalization for periods of seven to 14 days. Between these attacks, there was daily dyspepsia requiring treatment with antacids. In addition, he took laxatives frequently for chronic constipation. Twenty-five years before the present illness, cholecystotomy had been performed, and two years previously an epigastric hernia, which lay in the line of incision of the previous operation, was repaired in an effort to correct his symptoms. Multiple roentgen studies of the gastrointestinal tract during the years of his difficulty were interpreted as giving only normal results. Cholecystograms (figs. 1 and 2), made on Sept. 21, 1953, and interpreted by a visiting roentgenologist as giving negative evidence, were characteristic of emphysematous cholecystitis.

On physical examination, the temperature was 99 F., the pulse rate was 80, and the blood pressure was 160/84 mm. Hg. The patient was experiencing severe pain, and there was moderate tenderness to deep palpation in the epigastrium and the right subchondral area. Peristalsis was moderately increased. There was no rigidity or rebound tenderness.

Laboratory studies, all giving normal results, included a complete blood count; urinalysis; tests for serum bilirubin, serum amylase, serum chlorides, and blood urea nitrogen; a roentgenogram of the chest; an electrocardiogram, and a blood sugar determination. Preliminary roentgenograms of the abdomen with the patient in the recumbent and erect positions disclosed gaseous distention of considerable degree, involving principally the colon, but no radiopaque stones or fluid levels were demonstrated.

Conservative measures, consisting of intravenous fluids, analgesics, antispasmodics and dietary restrictions, were instituted. On the second day of hospitalization the tenderness was localized to the right hypochondrium. The temperature was 100 F. rectally. Except for this single elevation of temperature, the patient remained afebrile, but continued to complain intermittently of pain and tenderness. At no time was there clinical evidence of icterus.

On March 8, a cholecystogram demonstrated an oval-shaped gallbladder with good concentration of dye. A radiolucent shadow outlining the gallbladder had the appearance of air infiltrating its wall and the pericholecystic tissues (figs. 3 and 4). There was, however, no definite evidence of stones. The roentgenologic diagnosis was emphysematous cholecystitis.

At surgical exploration of the abdomen, performed by Dr. J. Brooks Brown on March 11, a shaggy gallbladder was encountered, which was completely walled off with surrounding omentum and fibrous adhesions. No attempt was made to recover air by introducing a needle into the wall of the gallbladder. In the process of removal, the gangrenous gallbladder fragmented. The wall was not significantly thickened, but showed extensive serosal adhesions. There was no evidence of stones in the gallbladder or cystic duct, but palpation of the common duct indicated distention of considerable degree, and at the level of the cystic duct several stones were palpated. Three nonfaceted stones then were delivered through a longitudinal incision in the common duct, and that structure was explored both proximally and distally. Since no further obstruction was encountered, a No. 18 T tube was inserted, the common duct closed and the procedure terminated.

Microscopically, sections of the removed gallbladder showed deep Aschoff sinuses with considerable chronic inflammation surrounding the sinuses and in the wall of





Figs. 3 and 4.—Cholecystograms before and after a fatty meal plainly delineate the radiolucent shadow surrounding the gallbladder cavity, which represents gas in the wall of the gallbladder. Some of the gas on the superior margin of the gallbladder appears diffused in the immediate pericholecystic tissues.

the gallbladder generally. A culture of the specimen was positive for Staph. aureus.

The postoperative course was uneventful. A cholangiogram on the eighth postoperative day failed to show evidence of stones. The patient was discharged from the hospital 10 days after the operation and up to the present time has remained clinically well.

Comment

In the case presented the clinical features, roentgen findings, surgical therapy, pathologic findings and favorable outcome all conform largely to the general pattern of the cases previously reported. How long emphysematous cholecystitis had been present is problematic, especially in view of the history of repeated episodes over a period of 30 years and definite evidence of gas in the gallbladder (figs. 1 and 2), demonstrated roentgenologically six months prior to operation but unrecognized at the time. The cholecystographic studies made immediately prior to surgical intervention demonstrated progression of the pathologic process to a late stage with infiltration of air into the wall of the gallbladder and into the pericholecystic tissues.

It is noteworthy that in this case, as in others, the gallbladder functioned remarkably well, as evidenced by good concentration of dye, in spite of the advanced stage of the disease.

Although conservative measures were at first employed, and for a considerable period of time in the past, cholecystectomy was undoubtedly the procedure of choice in this instance. Both the findings at operation and the long history of disease of the gallbladder suggest that it might well have been performed months earlier when the characteristic roentgen picture was not recognized, or perhaps even years earlier.

Between 1908 and 1940 only 7 authentic cases of this disease were reported, but during the decade of the 1940s 18 cases were recorded, most of them in the American literature. Since that time, reports of 9 more cases have been published. Undoubtedly, the 34 cases collected from the literature and the present case by no means constitute the entire series of recognized cases, and an even greater number doubtless have been overlooked or erroneously diagnosed. The present case emphasizes the need for awareness of this clinical entity on the part of the clinician, the roentgenologist and the surgeon and for recognition of the characteristic roentgen findings as the key to diagnosis.

Summary

The salient features of emphysematous cholecystitis are discussed. Since cholecystographic examination is the only means of preoperative

diagnosis of this definite clinical entity, emphasis is placed on the importance of recognition of the characteristic roentgen findings.

One case is described in which cholecystectomy was performed after conservative measures proved ineffectual. This is apparently the thirty-fifth case to be reported. Wider recognition of this severe infection of the gallbladder of bacterial origin with infiltration of air into the cavity of the gallbladder, its wall and the pericholecystic tissues would doubtless disclose a higher incidence than the small number of collected cases indicates.

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Weber's Syndrome: Report of a Case

Presenting a Diagnostic Problem

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Among the dilemmas facing the neurologic diagnostician is the perennial problem — which came first, the trauma to the head or the insult to the brain. In the patient in whom an extradural hematoma is a possibility the problem takes on a critical urgency.[1]

It is the purpose of this communication (1) to present a case in which the differential diagnosis rested between the traumatic and the metabolic categories, that is, extradural hematoma and infarction because of thrombosis due to atherosclerosis or to anoxemia, and (2) to re-emphasize the importance of percutaneous arteriography in the differential diagnosis of "stroke."[2,3]

Report of Case

J. G., a 62 year old right-handed known hypertensive man suffered a myocardial infarction one year before admission to the hospital on Feb. 10, 1953.

On the date of admission he had been at a restaurant having dinner. He arose from his chair and fell, striking his head against the wall. Some minutes later there developed difficulty with talking. This was followed by weakness of the right arm and hand. His wife said that although as far as could be determined there was no chest pain, he was given one of his nitroglycerin tablets. He vomited.

On physical examination at the time of admission the patient was stuporous. The blood pressure was 180 systolic and 130 diastolic, the pulse rate 98, respirations 24, and temperature 99.4 F. He responded to painful stimuli with movement of all extremities. The left pupil was dilated and did not respond to light. The right pupil was pinpoint. The fundi showed no evidence of papilledema. The motion of the extremities was intact, but the right arm moved less actively than the left. Pinprick was appreciated throughout. The deep tendon reflexes were active on the right side, but not elicitable on the left. No abdominal reflexes could be obtained.

Urinalysis was within normal limits. The blood count was 5,350,000 red blood cells, hemoglobin 14.7 Gm., and 16,000 white blood cells, with 65 per cent polymorphonuclears, 23 band forms and 9 lymphocytes. The VDRL test gave negative results. The nonprotein nitrogen was 54 mg. per hundred cubic centimeters and the blood sugar 100 mg.

Roentgen examination of the skull gave no evidence of fracture. The pineal gland was not calcified. Roentgenograms of the chest showed the heart to be grossly enlarged to the left, and a coin lesion, measuring 1.5 cm. in diameter, was present in the left central lung field.

An electrocardiogram showed no evidence of recent myocardial infarction.

Lumbar puncture revealed crystal clear cerebrospinal fluid. The initial pressure was 160 mm. of water. No cells were seen. The total protein was 71 mg. per hundred cubic centimeters.

At this point the Neurosurgical Service was consulted. It was decided that the history of trauma with subsequent stupor, dilated fixed left pupil and right-sided weakness were compatible with the diagnosis of extradural hematoma, although the clear spinal fluid under normal pressure, negative results of roentgen examination of the skull, and a history of severe arteriosclerotic disease would certainly favor intrinsic brain damage on a vascular basis.

Because of the urgency of the situation further information was essential. A left-sided percutaneous carotid arteriogram was performed under local novocain anesthesia. The roentgenologist's report read, "There is excellent visualization of the (left) internal carotid artery and its

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major branches which appear normal in pattern and distribution."

The diagnosis, therefore, became apparent. The arteriogram had ruled out a space-occupying lesion, such as extradural hematoma, and the diagnosis of partial infarction of the left midbrain tegmentum and peduncle by partial occlusion of the basilar artery due to atherosclerosis was made. This had produced Weber's syndrome,[4] a third nerve palsy on one side with hemiparesis of the opposite side of the body.

The patient was treated supportively. A complete third nerve palsy on the left side developed later, and he expired eight days after admission.

Autopsy Findings. — Autopsy, performed four hours postmortem, showed arteriolar nephrosclerosis, generalized arteriosclerosis, old myocardial infarction, old Ghon tubercle of the upper lobe of the left lung, and the following changes in the brain:

"The leptomeninges over the cerebral convexities are thin and transparent. The sulci are moderately widened. The gyri are narrowed, more markedly over the frontal lobes. The vessels at the base of the brain show moderate atherosclerotic changes. The posterior cerebral arteries come directly off the internal carotid arteries. There are no posterior communicatings. The basilar artery is joined by short insignificant branches to these posterior cerebral arteries. On sectioning the brain stem and separating the brain stem and cerebellum from the cerebral hemispheres, it is at once obvious that on the left side, there is an area of softening in the medial portion of the left peduncle, extending into the brain stem to the region of the nucleus of Edinger-Westphal (fig. 1). The brain was sectioned in coronal fashion. The ventricles are dilated throughout, to about 1½ times their normal size. In the region of the left thalamus posteriorly, medially and extending into the brain stem, there is an area of softening, which is reddish brown in color (fig. 2). This extends into the midbrain around the aqueduct into the left side of the tegmentum and into the left peduncle in its midportion, extending supero-inferiorly, for a distance of approximately 1 cm. and measuring from side to side, approximately 5 mm. There is no other evidence of hemorrhage, infarction or neoplasm, in the brain stem, cerebellum or cerebral hemispheres. Gross Diagnosis: Atherosclerosis of the vessels of the base of the brain, marked. Infarction of the midportion of the left cerebral peduncle in the brain stem, the left portion of the tegmentum of the brain stem and the left posterior thalamus, hydrocephalus ex vacuo, moderate cerebral atrophy."



Fig. 1. — This photograph shows the softenings in the left brain stem involving the region of the nucleus of Edinger-Westphal and the medial portion of the peduncle.

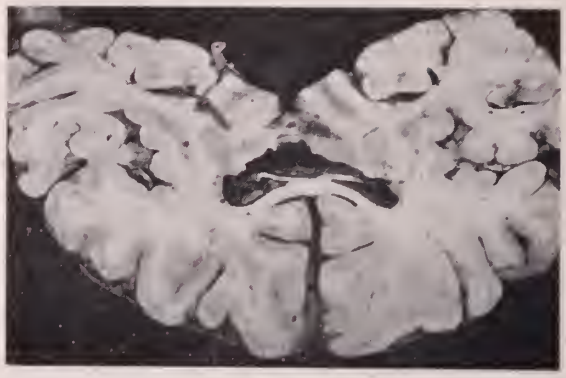


Fig. 2. — This photograph shows the extent of the infarct to involve the most posterior portion of the thalamus.

Discussion

In those cases in which the problem is to decide whether the insult to the brain preceded or resulted from an external trauma, percutaneous carotid arteriography can be of decisive diagnostic importance.

Summary

The clinical and pathologic findings in a case of Weber's syndrome are presented.

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ABSTRACTS

Salmonella in Fresh and Smoked Pork Sausage. By Mildred M. Galton, Willa Dean Lowery, and Albert V. Hardy. J. Infect. Dis. 95:232-235 (Nov.-Dec.) 1954.

This paper recounts the technics employed and the findings obtained in studies in which fresh and smoked pork sausage were examined for salmonellae in the Jacksonville area. The sources of these products were local abattoirs, local markets, regional abattoirs and national distributors.

Of 217 samples of fresh pork sausage examined for salmonellae, 51, or 23 per cent, were positive. The proportion positive varied according to the source of the specimen from a high of 57.5 per cent for the products of local abattoirs to the low of 7.5 per cent for the samples from national distributors. There were 127 examinations of smoked sausage, of which 16, or 12.5 per cent, were positive for salmonellae. The proportions positive varied as for the fresh sausage, the highest of 40.9 per cent being for the products from local abattoirs, followed by 14.4 per cent for those from local markets and 10.3 per cent for those from regional abattoirs. There was no positive in 49 samples of smoked sausage from national distributors. The types of salmonellae isolated, numbering 19, are tabulated and include all salmonellae isolated from pork sausage during these studies without regard to the culture technic employed. Comments are reserved for the concluding section of a companion paper, a review of which follows.

Salmonella in Swine, Cattle and the Environment of Abattoirs. By Mildred M. Galton, W. U. Smith, Hunter B. McElrath and Albert V. Hardy. J. Infect. Dis. 95:236-245 (Nov.-Dec.) 1954.

The frequent recovery, in the Jacksonville laboratory of the Florida State Board of Health, of salmonellae from pork sausage offered for sale in retail stores led to the investigation reported here of the prevalence of salmonellosis in animals and of salmonellae in the environment of abattoirs. In this study the findings tabulated cover salmonellae in living and dead hogs found by fecal cultures taken by rectal swabs and, in one group, by caecal swabs; salmonellae in the environment of abattoirs; salmonella isolations from the dehairing machine, and the apparently related skin contamination with salmonellae; the effect of extra cleansing of the dehairing machine on the occurrence of contamination with salmonellae in one abattoir; and the distribution of salmonella types in swine and the environment of abattoirs.

The findings led to the conclusion that a high proportion of hogs reaching the killing floor in the abattoirs examined harbor salmonellae in the enteric tract. It was evident that there are numerous sources for the spread of salmonellae to edible meat products, and that the major cause of the problem of salmonellae in these products is the spread of salmonellosis during the hours and days immediately prior to slaughter. It was clearly evident that there was a ready distribution of fecal pollution within the abattoirs, and the findings suggested that the presence of salmonellae in edible meat is the result primarily of the spread of pollution during processing.

Of the 12 commonest types of salmonellae found in man in Florida, 9 were among the 12 commonest types in swine. Thus the importance of pork products, including sausage, as a possible source of salmonellosis in man warrants emphasis. These studies clearly demonstrate the basic need for a proper concern for the bacteriologic quality of meat products, such as is shown in the public health control of the cleanliness, sanitation and safety of dairy products.

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Thanksgiving Meditation

Thanks be to God, . . .

Today when America faces what is probably the greatest challenge history has ever known, the rich deposits of inspiration left by preceding generations take on a new and vital significance. From the pinnacle of world leadership this great country must needs turn now to the tried and tested philosophies of the past to give perspective and understanding, lest she falter. Where better can she look for guidance than to the heritage of which perennially the Thanksgiving season serves as a reminder?

Urgent is the present need for faith and hope, for courage and peace of mind, for standards and ideals by which to live, and, above all in this atomic age, for an abiding belief in the future and in the progress of mankind. A genuine spiritual hunger stalks this fair land. The task is to assert the supremacy of the spiritual over the secular — to defend, to preserve, and to promote those intangible but nevertheless imperishable ideals that brought the founding fathers to these shores. Their faith in God, their passion for freedom, their belief in the individual and his rights, these this nation must make its own anew and proclaim them to the world.

Surely the medicine for a sick society is respect for the individual, not regimentation. Away with the "social salvation," the creeping socialism of which the nation has long had an overdose. With prophetic insight George Bernard Shaw said years ago: "Just as our predecessors had to fight for their spiritual freedom, for the right to worship God in their own way, so our successors will have to fight for their temporal (as well as spiritual) freedom, for the right to live their own lives and speak their own thoughts; and so the opposing creeds will not be Communism and Fascism, but Individualism and Collectivism, Independence and Subservience, Freedom and Slavery. The State was made for man, not man for the State; but unless human beings make the State their servant, it soon becomes their master. . . ."

The battle line is drawn, here and now, as American Medicine well knows. One crisis on health legislation is surmounted only to have another arise in the halls of government. Medicine stands in the forefront of the fray at this moment with a new onslaught imminent. America's greatest danger today is from within, and it cannot

be overemphasized that socialism is in reality communism with a time fuse. Medicine, as a modern Paul Revere, sounds the warning.

To be free men, Americans must make their stand upon the principles and ideals which brought this nation into being. Ultimately then, saved at whatever cost from the living death of slavery, they will be able to proclaim triumphantly, "Thanks be to God, who giveth us the victory. . . ."

Practical Program of Public Relations Five Major Aspects

V. Medical Society Unity

The keystone of the arch of medical public relations is the county medical society. Fundamentally, public relations is local. It is nevertheless essential that there be coordination and unity of purpose on local, state and national levels. The Florida Medical Association actually is a federation of 36 county medical societies located throughout the state. Its membership consists of the combined memberships of these county societies. It has no members except the county society members. In turn, it federates with other state and territorial medical associations to form the American Medical Association. So it is that the grass roots really count. Medicine is organized from the ground up, not from the top down, and the component county society is the basic unit. This is the democratic method of organization.

Appropriately enough, the fifth and last of this series of editorials on the Association's practical program of public relations deals with medical society unity. It is important that successful public relations projects and programs in any county medical society be made available to all component societies. Likewise, it is vital that the medical profession's relations with the public be strong everywhere. This goal is to be attained only when every practitioner of medicine makes it his concern to participate in promoting amicable understanding between the public and physicians, not only in his immediate community and in the state but in every nook and cranny of the nation.

In its efforts to promote harmonious cooperation, the Association seeks first to enlist the active interest and participation of all members in the affairs of organized medicine. Initially, this activity is manifest in the basic unit, the component county medical society. Every Association member is urged to take an active part in his county medical society. To this organization the public looks for leadership. In some areas the county medical society is an organization highly influential and respected; in other areas it has lost or failed to gain this position. As a rule, the reason for such failure is that a great many members do not attend meetings or take an interest in its activities. In areas where medical societies are inactive, other organizations acquire the support of the public, sometimes to the detriment of medical and public interest. A major objective of county societies is to demonstrate actively to the citizens of their community that they exist primarily for the betterment of medical care and public health in the community. Full realization of this aim requires the cooperation of all members.

A strong medical society is a society in which each and every member participates with enthusiasm because he is aware of the benefits of organized medicine and the importance of a good public relations program. What can you as an individual member do for the Florida Medical Association?

TAKE an active interest in the affairs of your county medical society. Help to promote the science and art of medicine at the local level. Enjoy there the full and frank interchange of views that leads to intelligent unity and harmony of the profession's opinion in all scientific, legislative, public health, material and social affairs, so that the profession may receive respect and support from within and also merit and receive good public opinion and respect from the community.

ATTEND all meetings of your county medical society to keep informed on current events and developments, and to exercise your right to a voice in the affairs and activities of organized medicine by the democratic method.

GIVE real cooperation to your local society officers and committee chairmen. They are the key men in the state organization.

KEEP in touch with the headquarters of the Association by sending in your suggestions on how its activities can be improved and expanded, by keeping the central office posted on events and developments in your community, and by replying promptly to correspondence received from the Association.

PROMOTE the work of your local county society and the Association by telling your patients, friends and acquaintances about their activities.

ASSIST in the public relations programs of your local society and the Association by holding the confidence and respect of your patients. Practice ethically. Render good medical service. Win the confidence of your patients. Thereby you be-

come a builder of good public relations for your profession.

SUPPORT the district and state meetings of the Association through your attendance and participation in the activities.

READ each month your Association's official publication, The Journal of the Florida Medical Association, so that you will know what your state association is doing and how you can support and promote its programs.

REMIT your annual dues promptly to your local treasurer. Neither your local society nor the Association can carry on the activities necessary to keep up to date unless they are financed adequately.

REMEMBER that your local society and the Association will be only as active, alert and effective as their individual members. Both are dependent on you and other members for support and ideas. You will get out of these organizations just as much as you put into them.

Indoctrination of members, interns, residents and medical students in the problems and programs of organized medicine pertaining to governmental medicine and socioeconomic affairs is the second major aspect of medical society unity stressed in the Association's public relations program. A well informed membership is imperative if the component county societies and the Association are to have unity, strength and warmth as organizations. More and more, medical societies are having to find a way to devote some of their meeting time to discussion of matters of political, sociologic, and economic nature, which are of supreme importance for the welfare of physicians and patients, without sacrificing the scientific programs. The duty of the members lies not only with the changing problems associated with the practice of medicine. They have a responsibility also to see that social changes are for the betterment of all the people and do not tend to become socialistic.

The membership must give careful and continuing attention, as Dr. James R. Reuling reminded the House of Delegates at the last A. M. A. meeting, not only to the economic problems of their patients but also to the economy of government at all levels. As citizens, they are called to be leaders in their individual communities and to use every effort to lend their training and knowledge to keep the body politic from becoming more seriously sick than it already is or from perchance changing the American way of life that it will die. As always, their best efforts must continue to be directed to what is best for the American people.

The Association is fortunate to have a Bureau of Public Relations with the personnel, the knowledge and the equipment necessary to implement its effective public relations program. Close liaison is maintained with the Board of Governors through the member of that body especially assigned to the task of putting into effect the policies set by the Board through the facilities of the Bureau. This important post is filled by Dr. Edward Jelks in his usual able manner. All of the Bureau's services and facilities are available to the component county societies in initiating projects and implementing local programs. Not only does the Bureau provide literature, radio platters, radio and television scripts, exhibits, displays and information for many other public relations projects, but it also serves as the contact unit with the press, radio, television, and other statewide lay organizations. The Supervisor of the Bureau, Mr. W. Harold Parham, expertly directs the activities and he and his assistant, Mr. Eugene L. Nixon, serve as a medium through which ideas are exchanged as they travel over the state assisting and advising members and component county society officials. They have an important role, too, as the Association's good will ambassadors among lay organizations.

As was mentioned in the introduction to this series of editorials, public relations for the physician may be summed up as a matter of attitude. What is your attitude, Doctor? Florida Medicine is on the march, pioneering and accomplishing. Are you keeping step? You owe much of your medical security today to the past activities of your medical societies. You have an obligation to those who follow. The task which confronts you offers a tremendous challenge — not to you alone, not to your county society alone, not to the Association alone, but to all of us together. Individually and collectively, we are public relations. If we all work together, success is assured.

New Medical Practices Assistance Grants

Physicians in need of financial aid to establish medical practice units may now find a helping hand in the assistance grants being offered by the Sears-Roebuck Foundation in cooperation with the American Medical Association. This plan pro-

vides long term, low cost assistance for young physicians, who often lack capital and business "know-how." It makes available unsecured 10 year loans of up to $25,000 to physicians seeking to establish practices but unable to get full local financing. Loans in at least one location in each of five regions covering the United States will be made in 1955 under an original $125,000 grant from the foundation.[1]

The program is planned for small or medium-sized towns, growing suburbs, or rural communities. It is designed to be self-expanding. All repayments will be used for further grants; the plan features advantages encouraging early repayment of grants to speed up establishment of more units.

A medical advisory board will screen the applications. This board has been appointed from nominations by the A. M. A. Board of Trustees. Each applicant is required to submit information about the area in which he intends to locate, indicating the need for medical care, medical resources already available, possible reasons for the success of a new practice, and benefits expected for the community. The representative for the South on this recently created medical advisory board is Dr. David Henry Poer of Atlanta, Ga.

The foundation states that its plan is intended to "realize the principles of opportunity, incentive, mutual help, and self reliance, to give the American people the best possible medical care, and to help the American physician build for himself the most effective, the most rewarding and the most satisfying life as a professional man."[2] Such a plan, relying on individual initiative and enterprise, requiring that assistance be given only where it will generate independence, and sustained entirely by those who benefit from it, surely deserves support. The reception this plan receives and the extent to which the medical profession supports it will determine its initial success and its continuation after 1955.

Physician placement services of the state medical societies will have a prominent role in getting the program started. They are prepared to furnish further information, as is the Council on Medical Service of the American Medical Association. Applications, however, go to regional directors. For this region they should be sent to the Director, Sears-Roebuck Board, 675 Ponce de Leon Ave., Atlanta, Ga.

1. "New Practice" Assistance Grants Offered, J. A. M. A. 159:38 (Sept. 3) 1955.
2. Establishing New Practices, J. A. M. A. 159:37 (Sept. 3) 1955.

Calling All Freedom-Loving Physicians Threat in Disability Benefits Legislation

Suddenly, the medical profession is confronted with the most serious national legislative crisis it has had to face since the attempt made in 1949-1950 to enact a system of national compulsory health insurance. An unexpected legislative blitz in the United State House of Representatives on July 18 has placed American Medicine in an extremely dangerous position, of which every member of the profession must be made fully aware. By a roll call vote of 372 to 31, the House passed H. R. 7225, known as the Social Security Amendments of 1955. This bill, which would amend the law to provide cash benefits to certain beneficiaries who are permanently and totally disabled, was rushed through the House under a procedure suspending the rules, barring amendments, limiting debate to 40 minutes, and requiring a two-thirds vote of approval. Earlier the House Ways and Means Committee in executive session had reported out the measure without public hearing and over the protests of Republican committee members who demanded open hearings and careful study of the legislation.

This action in itself — not to mention the way in which it was railroaded through the House — is nothing short of a piecemeal approach to the socialization of medicine. It offers a glaring example of the back door approach of creeping socialism. At the time of its passage the Board of Trustees of the American Medical Association, alert to the threat to present medical freedom, was exerting every effort to prevent adoption of this far-reaching change in the Social Security Act, albeit in the face of the fact that previous proposals to expand the Social Security Act had received almost unanimous bipartisan political support.

Since the House action is so important and since it is expected that the bill will be considered by the Senate immediately after the Congress convenes in January, there is time to educate the profession as to the legislative dangers to be confronted not in the future but now. Certainly every freedom-loving physician will wish to familiarize himself thoroughly with this bill and its import and will be eager to do his part in defeating it in the Senate. Particular attention is directed to a special message from the A. M. A. Board of Trustees published on page 1032 of the

(Continued on page 400)

Quiz
for
doctors

(you probably know every answer!)

Q. Which is today's most widely prescribed broad-spectrum antibiotic?

A. ACHROMYCIN -- it's first by many thousands of prescriptions.

Q. What are some of the advantages of ACHROMYCIN?

A. Wide spectrum of effectiveness.
Rapid diffusion and penetration.
Negligible side effects.

Q. Exactly how broad is the spectrum of ACHROMYCIN?

A. It has proved effective against a wide variety of infections, caused by Gram-positive and Gram-negative bacteria, rickettsia, and certain viruses and protozoa.

Q. In what way are ACHROMYCIN Capsules advantageous?

A. For rapid and complete absorption they are dry-filled, sealed capsules (a Lederle exclusive!) No oils, no paste...tamperproof.

Q. Who makes ACHROMYCIN?

A. It is produced -- every gram -- under rigid quality control in Lederle's own laboratories and is available only under the Lederle label.

CHROMYCIN*

Hydrochloride
Tetracycline HCl Lederle

Lederle

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY PEARL RIVER, NEW YORK

*REG. U.S. PAT. OFF.

(Continued from page 397)

July 23 issue of The Journal of the American Medical Association, to a press release from its chairman on page 1036 of the same issue, reprinted for the information of readers, and to an article entitled "Compulsory Case Disability Benefits — the Legislative Blitz" appearing on page 1442 of the August 20 issue of the A. M. A. Journal. The last named is by A. L. Kirkpatrick, noted insurance journalist and manager of the insurance department of the Chamber of Commerce of the United States and is the first of a series to be published in that journal concerning the proposal to establish a national system of cash benefits for persons totally and permanently disabled. It also is the first article in the new A. M. A. pamphlet now available on social security, covering all aspects of this proposal. All physicians are urged to acquaint themselves with the facts on this vital issue.

If the Senate should permit this bill to become law, it can be confidently predicted that the cash disability benefits will gradually be extended to the temporarily disabled and that eventually a system of compulsory health insurance will be initiated by the federal government as a necessary counterpart to the cash benefits program. There has been this combination of national compulsory health insurance and national disability benefits in almost every other nation where government disability benefits exist. Since the government must control the treatment of the disabled if it is to maintain any control over the extent of the cash benefits, the combination becomes inevitable. The present bill, in fact, requires concurrent rehabilitation for the permanently and totally disabled, on which the cash benefits will be contingent.

This legislation, if enacted, may be expected to have on existing health insurance and medical practice about the same effect as it has had in countries where such legislation has been in force for some time. Fortunately, there is time, though all too brief a period remains, for the profession to become thoroughly aware of the true nature of this bill and its effect on health insurance and medical practice, and to take active steps to develop a public climate that will permit the members of the Senate to vote against it. As the A. M. A. Trustees stated in their special message: "The distance between our present medical freedom and complete government regimentation has narrowed considerably. The remaining gap will be closed completely unless physicians throughout the nation take constructive action to educate themselves, the public, and their congressmen and senators during the next few months."

In succeeding issues The Journal of the Florida Medical Association will publish as much information as possible for the convenience of the membership.

A. M. A. Clinical Meeting Boston, Nov. 29 - Dec. 2

From Miami's sunny shores in 1954, the Clinical Meeting of the American Medical Association turns in 1955 to Boston with its historic setting and modern attractions. The ninth assembly of this popular winter attraction opens on November 29 and closes on December 2. This clinical meeting has developed a distinctive pattern since its inception at Cleveland in 1948 and has become an outstanding contribution to graduate medical education. One of the largest clinical meetings yet held is anticipated.

The program will be presented in three lecture halls simultaneously and continuously, an arrangement which offers the many visiting physicians, representing all branches of medicine, a wide variety of subjects from which to choose. The lectures and round table discussions, arranged by the local committee in Boston, will cover all phases of medicine. The operating room will come to the lecture hall through color television, originating at New England Deaconess Hospital. The program of both medical and surgical subjects will be outstanding. There will be a continuous presentation of motion pictures, carefully selected and in some instances supplementing other features of the program, with many of the authors present to discuss their films.

The Scientific Exhibit as usual will have many attractive features. Outstanding authorities will be available continuously to answer questions and discuss problems with other physicians. The fracture exhibit and the manikin demonstrations on problems of delivery, with experts present for consultation, will be especially noteworthy features. In addition, the Technical Exposition provides a display by all leading medical supply firms showing what is new in equipment, books and pharmaceuticals.

The Mechanics Building will house all scientific activities. This historic structure will meet the needs comfortably. The House of Delegates will hold its meetings in the Statler Hotel. Boston never lacks for attractions, and Concord and Lex-

ington are nearby. It is expected that the program of this meeting, built against a fascinating background of medical history, will make this 1955 fall meeting particularly worth while.

Two postconvention travel tours are arranged to include medical meetings of our Caribbean neighbors. President Elmer Hess will lead one party on a Caribbean Air Cruise from December 2 to 11, with stops in Puerto Rico, Haiti, and Jamaica. Invitations have been extended to cruise members to attend sessions of the Puerto Rico Medical Association's 1955 annual meeting in San Juan on December 6 and 7. They have also been invited to attend a special session of the annual medical conference of the Jamaica branch of the British Medical Association, scheduled for Kingston on December 9. Full information regarding this cruise may be obtained from International Travel Service, Inc., Palmer House, Chicago 3. A tour to Nassau, covering the same period as the Caribbean tour, will be featured by a specially arranged medical meeting of the Bahamas Medical Association at the Jungle Club in Nassau. A. M. A. Nassau Tour headquarters, 35 East Monroe St., Chicago 3, will furnish the details of this trip.

Southern Medical Association
Houston, November 14 - 17, 1955

The Southern Medical Association will hold its forty-ninth annual meeting in Houston, Texas, beginning on Monday, November 14, and continuing through Thursday noon, November 17. This second largest general medical meeting in the United States features a wide variety of attractions of interest to physicians in all branches of medicine.

The Scientific Assembly, composed of 20 sections, offers a broad and varied program, of interest to specialist and general practitioner alike. Some 250 scientific papers will be presented in the various sections. In addition, 50 specialized papers will be read before six other regional and specialty societies meeting conjointly with the Southern Medical Association.

Members of the Florida Medical Association listed on the preliminary program as presenting papers and their subjects are: Benjamin G. Oren and J. Ernest Ayre, of Miami, "An Evaluation of Gastric Cytology;" Walter W. Sackett Jr., of Miami, and John E. Crews, of Orlando, "A Report on Use of Three Meals a Day and the Introduction of Solid Foods from Birth in Infant Feeding;" and Eugene L. Jewett, F. DeWitt Stanford and Louis P. Brady, of Orlando, "Subtrochanteric Fracture of the Hip Treated with a Dual Flanged Hip Nail." Other members who will discuss papers include Dr. Joseph A. Farrington, of Jacksonville, Dr. Donald F. Marion, of Miami, and Dr. Charles J. Collins, of Orlando. Dr. Emil M. Isberg, of Miami, will participate in a panel discussion on "The Relationship of Life Stress to Gastrointestinal Symptoms and Disease."

At the first general session, scheduled for 10:30 a.m. on Monday, November 14, President R. L. Sanders will deliver his presidential address, entitled "Values in Medicine." Dr. Francis P. Gaines, President of Washington and Lee University, Lexington, Va., will then deliver an address on "The Range of Loyalty." On Wednesday night a feature of the second general session will be the installation of the incoming president, Dr. W. Raymond McKenzie, of Baltimore. The annual dinner dance will follow.

General headquarters hotel for the convention will be The Shamrock, where all meetings will be held. Free bus transportation will be provided from the major downtown hotels to The Shamrock. There will be no registration fee for members. Fifteen alumni and fraternity reunions have been scheduled. There will be conducted tours of the Texas Medical Center. A postconvention tour to Mexico has been arranged. Certainly a most rewarding attraction will be Southern hospitality — Texas style.

Medical TV
1955-1956 Season

The impact of television in the shaping of public opinion has in a few short years become tremendous. This approach, characterized by an intimacy not achieved by any other medium of communication, reaches simultaneously vast numbers of urban and rural families throughout the nation.

Approximately 36,500,000 was the estimated number of television sets in the United States as of July 1, 1955, a figure which represents an increase of 2,600,000 sets during the first half of this year. There are 406 television stations now operating in 253 cities. Audiences for some individual programs have reached as high as 60,000,000 people for one presentation.

A favorite among subjects for television is medicine. Whether the medical profession likes it or not, medicine is held up for scrutiny by the

TV public dozens of times a month on dramatic shows, in newscasts, and in educational presentations wherever television stations are in operation.

For the 1955-1956 season the national TV networks are carrying five regularly scheduled medical television programs with a combined potential audience of 75,000,000 people each week. Motion picture producers are filming several program series on medical themes for use by commercial sponsors on local stations. In addition, 10 state medical societies and 99 county medical societies currently are putting on local TV shows or are planning to do so, according to recent surveys by the American Medical Association.

The five network shows now in progress are: "Medic," "March of Medicine," "Dr. Spock," "Medical and Health News with Howard Whitman," all over the NBC-TV network, and "Medical Horizons," over the ABC-TV network. "Medic" is seen at 9 p.m. Eastern Time three Mondays out of four over 82 NBC-TV stations in the United States and over 28 stations in Canada. This show is carried by WFLA-TV in Tampa. The "March of Medicine" series at 9:30 Eastern Time is presented on 73 stations; the next telecasts are scheduled for the first week in November and the first week in December. The December telecast will cover scientific presentations made at the Clinical Session of the American Medical Association, to be held in Boston at that time. This NBC-TV series is scheduled in Florida over WGBS in Miami, WJNO-TV in Palm Beach, and WFLA-TV in Tampa. The new ABC-TV network series of programs, seen at 9:30 p.m. Eastern Time each Monday over 45 stations for a minimum of 26 weeks, is entitled "Medical Horizons." It began in mid-September and emanates via live remote telecasts from medical institutions and research centers, presenting specific accomplishments brought about by the teamwork of modern medical research, education and practice. This program is carried by WJHP-TV in Jacksonville. It is also presented by delayed broadcast in St. Petersburg by WSUN-TV at 9:30 p.m. on Tuesday.

Last month Dr. Benjamin Spock began an NBC-TV series of half-hour telecasts at 3 p.m. Eastern Time on Sunday, presenting the subject of child care and development. The format is varied, covering many questions dealing with child-rearing both from the medical and from the psychologic viewpoints.

On NBC-TV's popular "Home" show each Wednesday morning, the author-commentator Howard Whitman reports for 10 minutes on the latest medical and health news under the caption of "Medical and Health News with Howard Whitman." He scouts, edits and presents in concise, understandable form such medical information as developments in new antibiotics and drugs and new treatments being developed for various diseases.

"It's Baby Time," a new filmed television program to be seen over local TV stations throughout the country, has the cooperation of the American Medical Association. It is a 15 minute feature, scheduled to begin October 16, which takes up common problems in the development and feeding of healthy babies. Sponsored by Libby's Baby Food, this program will feature Dr. W. W. Bauer, director of the A.M.A. Bureau of Health Education, as medical narrator, and Jane Warren, R.N., as demonstrator of nursing procedures. Unlike the live network television programs with which the American Medical Association cooperates, "It's Baby Time" will be filmed and placed on individual stations. The time and date for the program will vary from community to community. This program has been scheduled for the Tampa-St. Petersburg area once a week on Thursday at 2:15 p.m. over WFLA-TV, and also for Miami on Monday at 9:45 a.m. over WTVJ.

This new educational medium, yet in its infancy but already of extraordinary scope, offers a challenge to the medical profession that is being met constructively. The opportunity at hand offers much for the future both for medicine and for the public.

Physicians Lend Support to Science Fairs for Students

A practical demonstration of leadership by the medical profession in the broad field of science was given last spring when physicians of three Indiana counties joined in sponsoring the Northwestern Indiana Regional Fair held at the Chesterton high school. This was one of many regional shows held all over the country in connection with the Sixth Annual National Science Fair, with two winners from each region competing for national titles at Cleveland in May.

"This is a natural for the medical profession," said Dr. Ralph C. Eades, of Valparaiso, who organized and served as chairman of the committee of doctors from Porter, Lake, and LePorte coun-

ties. "The project," he added, "should be supported locally by medical societies throughout the country. Each medical society should have a special committee to work with school authorities in their communities."

Dr. Eades offered three valid reasons why, from the standpoint of the profession, doctors should support the project locally:

"1. It places the medical profession in direct contact with a group of scientifically-minded youngsters and provides a fertile field from which to draw our future physicians and members of professions allied to medicine.

"2. It will be hard to sell scientifically trained young Americans on cultism and quackery, for their scientific training wil enable them to distinguish between the true and the false.

"3. The work of these youngsters is an example of what can be accomplished through American individual initiative."

Medical exhibits covered many subjects, including digestion, anatomy, tooth decay, reducing pills, chemistry in cosmetics, water testing, tooth paste, mineral deficiency in plants, water filtration, diabetes, effects of preservatives on bacterial growth, and hormone feeds. One particularly ingenious device shown was an automatic book page turner built for a polio victim whose chest and arms had been paralyzed. The page turner was operated by a foot-controlled push button.

This type of opportunity to help lay the groundwork for scientific careers merits the cooperation of county medical societies and could well win many a worthy recruit for medicine. In Florida, the winter season is the favored time for fairs, and many an alert county medical society will respond gladly when this new opportunity comes knocking at the door.

Precaution Advised About Soviet Medical Propaganda

Recently throughout the country physicians have received a mimeographed publication called "American Soviet Facts," containing 21 half-pages of "up-to-date information" on "Health and Medical Care in the U.S.S.R." This material is published by the National Council of American-Soviet Friendship, 114 East 32nd Street, New York 16. New York, one of the leading communist propaganda agencies in the United States.

As a safeguard against any suspicions of communist sympathies, Dr. George F. Lull, Secretary-General Manager of the American Medical Association, advises physicians who wish to keep the record straight to write to the National Council of American-Soviet Friendship, requesting that their names be taken off that organization's mailing list. A carbon copy of the letter should be sent to the nearest office of the Federal Bureau of Investigation or to the F.B.I. in Washington, along with the propaganda material received. This precaution is advised because records are kept of persons receiving communist literature for any considerable length of time.

Executives' Eating Habits Restaurateur's Research

Research of a restaurateur brings to light what some doctors have long known: never trust the average executive with his own stomach.[1] For two decades a Chicago Loop establishment has been victualing businessmen, lawyers and accountants, but only recently did the proprietor discover that "the average executive who could be trusted with a gin bottle shouldn't be left alone for a minute with his own stomach." It seems that "he usually omits breakfast, often lunches at his desk, and likes a well-done deal as much as a medium-rare steak for dinner."

Weary of complaints about too little gin in the Martinis, this researching restaurateur set out the bottles for the customers to help themselves, only to find that they used about the same amount of liquor as his bartenders. He arrived at his conclusions about executives' eating habits after analyzing 10,000 questionnaires filled out by businessmen and women.

His study revealed that nearly 90 per cent eat no breakfast and the remainder sacrifice perhaps five minutes for "a ritual gulp." Thirty minutes is a liberal allowance for lunch, and, unless there is business to transact over a table, merely wolfing a sandwich at their desk suffices. Among the advertising and public relations men 79 per cent reported stomach troubles, but only 16 per cent of construction executives reported gastric ailments.

As for food preferences, the survey showed that most presidents and vice presidents, 86 per cent in fact, have a decided preference for meat and potatoes. Younger executives, on the other hand, choose the more exotic dishes. In the matter of skipping breakfast and preferring staple foods, the women executives parallel their male counterparts.

This unique bit of research offers food for thought to the physicians who count the average executive among their patients. It might even provide a diagnostic clue or two.

1. Meat and Potatoes, Newsweek, April 4, 1955, p. 74.

STATE NEWS ITEMS

Dr. G. Dekle Taylor of Jacksonville has been appointed a member of the Duval County Welfare Board.

Dr. Charles J. Heinberg of Pensacola discussed automobile safety at a late August meeting of the Kiwanis Club there.

Dr. James J. DeVito of St. Augustine has returned from Boston where he took a postgraduate course at the Harvard University Medical School.

Dr. Roger D. Sherman of Warrington was principal speaker at a recent meeting of the Rotary Club at Pensacola. He discussed the alcoholic rehabilitation program of the state of Florida.

Dr. Barney Weinkle of Miami Beach has been honored by the city employees there for "his courtesies and his services beyond the call of duty." Dr. Weinkle was presented a plaque as tribute.

Drs. Mason Trupp, Ernest R. Bourkard and H. Phillip Hampton of Tampa, and Dr. Sidney Grau of St. Petersburg were principal speakers on the program of the two day legal institute sponsored recently by the Tampa and Hillsborough County Bar Association.

Dr. Jere W. Annis of Lakeland discussed the problem of gaining and maintaining mental health at a mid-September meeting of the Winter Haven Pilot Club.

Dr. Frank C. Metzger of Tampa was principal speaker at a recent meeting of the Palma Ceia Kiwanis Club.

Dr. Maurice Lev of Miami Beach was guest speaker at a recent regular meeting of Miami Beach Lodge No. 1591, B'nai B'rith. The subject of his address was "Progress of Medical Research."

Dr. Walter C. Payne Sr. of Pensacola has been reappointed by Governor LeRoy Collins to the Advisory Hospital Council for the state of Florida. Dr. Payne also has been reelected president of the Escambia County Blood Bank.

Dr. S. Roy Higginbotham of Tampa attended the meeting of the International College of Surgeons held at Philadelphia the last of September.

Dr. Fred D. Bartleson of Ft. Myers has returned from Philadelphia where he attended the meeting of the International College of Surgeons.

Dr. Clarence M. Sharp of Jacksonville was guest speaker at the September meeting of the Okaloosa County Tuberculosis and Health Association held at Fort Walton Beach.

Dr. Kenneth A. Morris of Jacksonville has been appointed chairman of a committee to supervise the operation of the Duval-Brewster School of Nursing at Jacksonville.

Dr. Millard B. White of Sarasota was principal speaker at a recent meeting of the Sarasota Rotary Club. Dr. White is the first county medical examiner for Sarasota county. He related some of his experiences to the Club.

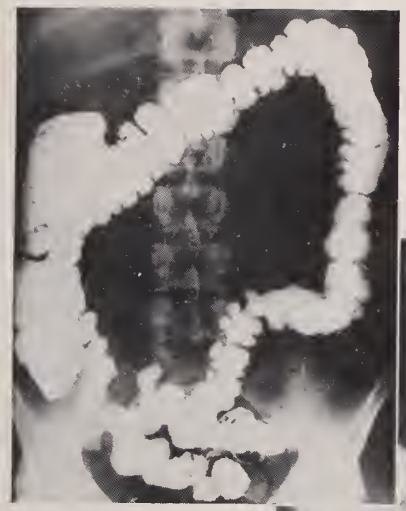
Dr. George H. Warren who has been practicticing at Perry for 41 years was honored by his fellow townspeople the first of September with festivities planned "as an expression of the esteem in which Dr. Warren is held by local citizens." A public barbecue terminated the day long program.

Dr. Wade S. Rizk of Jacksonville was guest speaker at a meeting of the Railway Business Women of Jacksonville held the middle of September.

Dr. James A. Sewell has returned to his practice at Melbourne after completing a surgical residency at the University Hospital in Baltimore, Md.

Dr. Harry F. Watt of Ocala presented a paper on the "Treatment of Bites of Poisonous Snakes" at a seminar at Bowman-Gray School of Medicine, Winston-Salem, N. C., in August.

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It is indicated in chronic constipation of various types—including distal colon stasis of the "irritable colon" syndrome, the atonic colon following abdominal operations, repressions of defecation after anorectal surgery and in special conditions such as the management of a permanent ileostomy. Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent.

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SEARLE

Dr. J. Champneys Taylor of Jacksonville attended the recent meeting of the American Association of Obstetricians and Gynecologists held at Hot Springs, Va.

Dr. Louis H. Clerf addressed the medical staff at the Veterans Administration Center at Bay Pines on September 30. All physicians in the area were invited to hear Dr. Clerf lecture at noon on "Paralysis of the Larynx" and at night, following a dinner meeting at the Detroit Hotel in St. Petersburg, on "Significance of Certain Respiratory Symptoms of Medical Interest." Dr. Clerf recently retired as professor of laryngology and bronchoesophagology at the Jefferson Medical College of Philadelphia and has been for many years a distinguished leader in his specialty. He is now a resident of Florida, making his home in St. Petersburg.

Plans have been formulated to erect at Sneedville, Tenn., a statue in honor of the frontier circuit rider doctor. To be carved from marble at a cost of approximately $16,000, the statue is to be erected with funds that will be wholly contributory. Physicians desiring to have a part in the understaking should contact Mr. Otis H. Greene, county court clerk, Hancock County, Sneedville, Tenn.

Dr. Maurice H. Greenhill has been appointed head of the department of psychiatry at the University of Miami School of Medicine and director of the Psychiatric Institute. He was formerly professor of psychiatry at the University of Maryland School of Medicine.

Medical Officers Returned

Dr. Edward T. Buford Jr., (Col.) who entered military service on April 22, 1953, was released from active duty on April 11, 1955 with the rank of captain, U. S. Army. His address is 1500 Louisiana Ave., Panama City.

Dr. Donald E. Fortner, who entered military service on July 1, 1953, was released from active duty on June 30, 1955, with the rank of captain, U. S. Army. His address is 5800 S. W. 73rd St., South Miami.

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GUEST SPEAKERS

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J. Lowry Miller, M.D., New York, N. Y. Dermatology
Franz J. Ingelfinger, M.D., Boston, Mass. Gastroenterology
John I. Brewer, M.D., Chicago, Ill. Gynecology
S. Gilbert Blount, Jr., M.D., Denver, Colo. Internal Medicine
Eugene A. Stead, Jr., M.D., Durham, N.C. Internal Medicine
John H. Talbott, M.D., Buffalo, N. Y. Internal Medicine
Lawrence S. Kubie, M.D., New York, N. Y. Neuropsychiatry
Duncan E. Reid, M.D., Boston, Mass. Obstetrics
Frank W. Newell, M.D., Chicago, Ill. Ophthalmology
Claude N. Lambert, M.D., Chicago, Ill. Orthopedic Surgery
A. C. Hilding, M.D., Duluth, Minn. Otolaryngology
Alan R. Moritz, M.D., Cleveland, Ohio Pathology
Joseph A. Johnston, M.D., Detroit, Mich. Pediatrics
Philip J. Hodes, M.D., Philadelphia, Pa. Radiology
Arthur H. Blakemore, M.D., New York, N. Y. Surgery
Charles G. Child, III, M.D., Boston, Mass. Surgery
Rubin H. Flocks, M.D., Iowa City, Iowa Urology

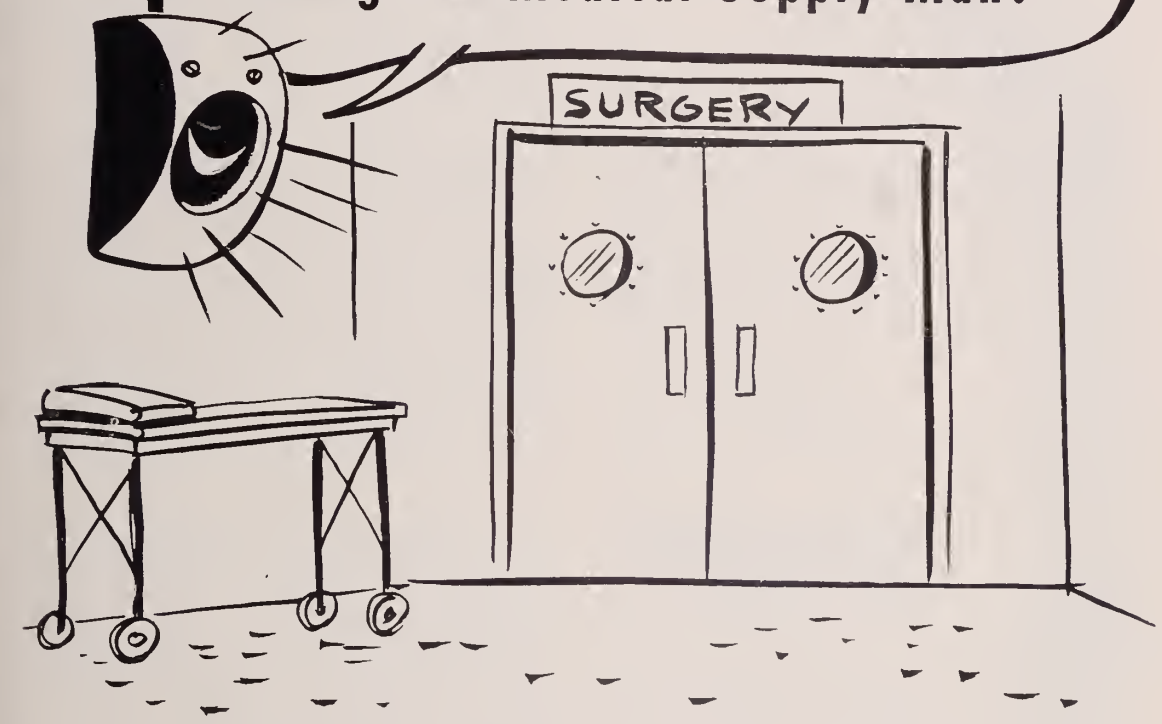
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For information concerning the Assembly meeting and the tour write Secretary, Room 103, 1430 Tulane Avenue, New Orleans 12, La.

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COMPONENT SOCIETY NOTES

Dade

A discussion of "Blue Shield's New Increased Fee Schedule" was a feature of the October meeting of the Dade County Medical Association. Principal speaker was Mr. H. A. Schroder, executive director of the Florida Blue Shield Plan.

Duval

A symposium on insurance medicine made up the program for the October meeting of the Duval County Medical Society. Speakers included Drs. John F. Lovejoy, Richard A. Nelson, Paul V. Reinartz and John A. Wilhelm. Dr. Lovejoy's subject was "Surgical Aspects of Insurance Selection," Dr. Nelson's "The Electrocardiogram in Insurance Selection," Dr. Reinartz's "The Challenge of Health Insurance" and Dr. Wilhelm's "Medical Advances in Insurance Selection."

Escambia

The Escambia County Medical Society has presented the Pensacola Community Chest a check for $7,250 in the annual Red Feather campaign. This represents the largest gift in the history of the medical division of the local Community Chest. Dr. Gretchen V. Squires, of Pensacola, chairman of the medical division, in making the presentation stated that the action was conceived by the Society membership as a tangible demonstration of their belief in the community, and as an expression of their appreciation of the honor conferred upon the profession by the election of Dr. Paul F. Baranco as president of the Community Chest for 1955.

Hillsborough

Kodacolor movies shown by Drs. Richard G. Connar and Hawley H. Seiler, both of Tampa, made up the program for the October meeting of the Hillsborough County Medical Association. Dr. Connar's film was tittled "Excision Mitral Commisurotomy," and Dr. Seiler's "Mediastinal Teratoma."

Lake

Dr. Newton C. McCollough of Orlando was one of the guest speakers at the September 7 meeting of the Lake County Medical Society held at Howey-in-the-Hills. His subject was "Congenital Deformities."

Pork in the Dietary During Pregnancy and Lactation

CERTAIN NUTRIENTS are required in greater than normal amounts during pregnancy and lactation. Pork meat, though its cost is low, supplies a remarkably high quantity of the nutrients required by the maternal organism in these periods of physiologic need

During pregnancy the maternal organism may store 3.3 to 5.5 pounds of protein in excess of that contributed to fetal tissue.[1] Enough iron is stored to approximate the entire amount secreted in the milk during 9 months of lactation, in addition to the iron supplied to the fetus.[2]

The body of the newborn infant contains approximately 500 grams of protein, 14 grams of phosphorus, and 0.5 gram of iron.[3] It is estimated that the lactating mother, through breast milk, provides a 26 week old infant with about 12 grams of protein, 76 grams of lactose, and 1.2 mg. of iron each day.[2]

Pork meat, an excellent source of high quality protein, thiamine, niacin, and iron,[4] also supplies valuable amounts of other B vitamins, as well as phosphorus, magnesium, and potassium. The thiamine content of pork is particularly important, since there are few more valuable food sources of this vitamin.[4]

Pork and pork sausage—economical, good tasting—are valuable components of the dietary of the pregnant or lactating woman. Just how valuable, is shown in the table below.

1. Toverud, K.U.; Stearns, G., and Macy, I.G.: Maternal Nutrition and Child Health, an Interpretative Review, Washington, D.C., National Research Council, Bull. 123, 1950.

2. McLester, J.S., and Darby, W.J.: Nutrition and Diet in Health and Disease, ed. 6, Philadelphia, W.B. Saunders Company, 1952, p. 241.

3. Marrack, J.R.: Food and Planning, London, Victor Gollancz, Ltd., 1943, p. 67.

4. Wolgamot, I.H., and Fincher, L.J.: Pork Facts for Consumer Education, Washington, D.C., United States Department of Agriculture, AIB No. 109, 1954.

5. Watt, B.K., and Merrill, A.L.: Composition of Foods—Raw, Processed, Prepared, Washington, D.C., United States Department of Agriculture, Agricultural Handbook No. 8, 1950.

6. Bowes, A. deP., and Church, C.F.: Food Values of Portions Commonly Used, ed. 7, Philadelphia, Anna dePlanter Bowes, 1951.

Percentages of Recommended Daily Dietary Allowances* for Pregnant (3rd Trimester) and Lactating Women Provided by 3-Ounce Portions of Cooked Pork Meats and Pork Sausage

	Protein	Iron	Phosphorus	Thiamine	Riboflavin	Niacin	Calories
PREGNANCY (3rd trimester)							
Ham, without bone, 3 oz., cooked[5]	25.0%	17.3%	13.5%	30.0%	10.0%	26.7%	12.5%
Pork Chops, without bone, 3 oz., cooked[5]	25.0%	17.3%	13.3%	47.3%	10.0%	28.7%	10.5%
Pork Sausage, 3 oz., cooked[6]	17.3%	14.0%	9.2%	27.7%	10.1%	18.5%	14.7%
LACTATION							
Ham, without bone, 3 oz., cooked[5]	20.0%	17.3%	10.1%	30.0%	8.0%	26.7%	10.2%
Pork Chops, without bone, 3 oz., cooked[5]	20.0%	17.3%	10.0%	47.3%	8.0%	28.7%	8.6%
Pork Sausage, 3 oz., cooked[6]	13.8%	14.0%	6.9%	27.7%	8.1%	18.5%	12.0%

*Recommended Dietary Allowances, Washington, D. C., National Academy of Sciences—National Research Council, Publication 302, 1953

The nutritional statements made in this advertisement have been reviewed and found consistent with current medical opinion by the Council on Foods and Nutrition of the American Medical Association.

American Meat Institute
Main Office, Chicago... Members Throughout the United States

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The following doctors have joined the State Association through their respective county medical societies.

Asbury, Clyde E., Jr., Lakeland
Bechtel, Jack T., Eau Gallie
Connar, Richard G., Tampa
Hardee, Howard D., Tampa
Head, Thomas D., Crawfordville
Horton, James A., Live Oak
Huntington, Frederic S., Delray Beach
Kidder, Richard F., Lake Worth
O'Hara, Bernard F., West Palm Beach
Rowe, Daniel H., West Palm Beach
Witt, Governor M., West Palm Beach

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Retired ophthalmologist, Florida license, F.A.C.S., Diplomate Board of Ophthalmology, will act as Locum Tenens for those desiring vacation, etc. Keep this ad as appears only once. Write 69-163, P.O. Box 1018, Jacksonville, Fla.

INDUSTRIAL MEDICINE: Physician with Florida license interested in industrial medicine. Full time position available in Cocoa area. Write full resume to Industrial Relations Department, Pan American Airways, Inc., P.O. Box 308, Officers Mail Unit, Guided Missiles Range Division, Patrick Air Force Base, Cocoa, Fla

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BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Eugene M. Frame of Jacksonville announce the birth of a son, David Longwell, on Sept. 23, 1955.

Dr. and Mrs. James E. Cousar III of Jacksonville announce the birth of a son, Charles Donaldson, on September 6, 1955.

Dr. and Mrs. Cecil B. Brewton of Fernandina Beach announce the birth of a son, William Caraway, on September 8, 1955.

Dr. and Mrs. Leonard H. Grunthal Jr. of Jacksonville announce the birth of a son, Leonard Harrison III, on September 9, 1955.

Dr. and Mrs. Daniel Kindler of Miami announce the birth of a daughter, Laura, on August 28, 1955.

Marriages

Dr. James F. Speers of Titusville and Mrs. Jean Bellflower were married August 26, 1955, in Titusville.

Dr. Herman Cohen of Miami Beach and Miss Libby Gewitz were married September 9, 1955, in Miami Beach.

Deaths — Other Doctors

Askew, Rufus A., Atlanta, Ga. July 5, 1955
McDonald, Charles W., Jacksonville, Fla. Oct. 1, 1955





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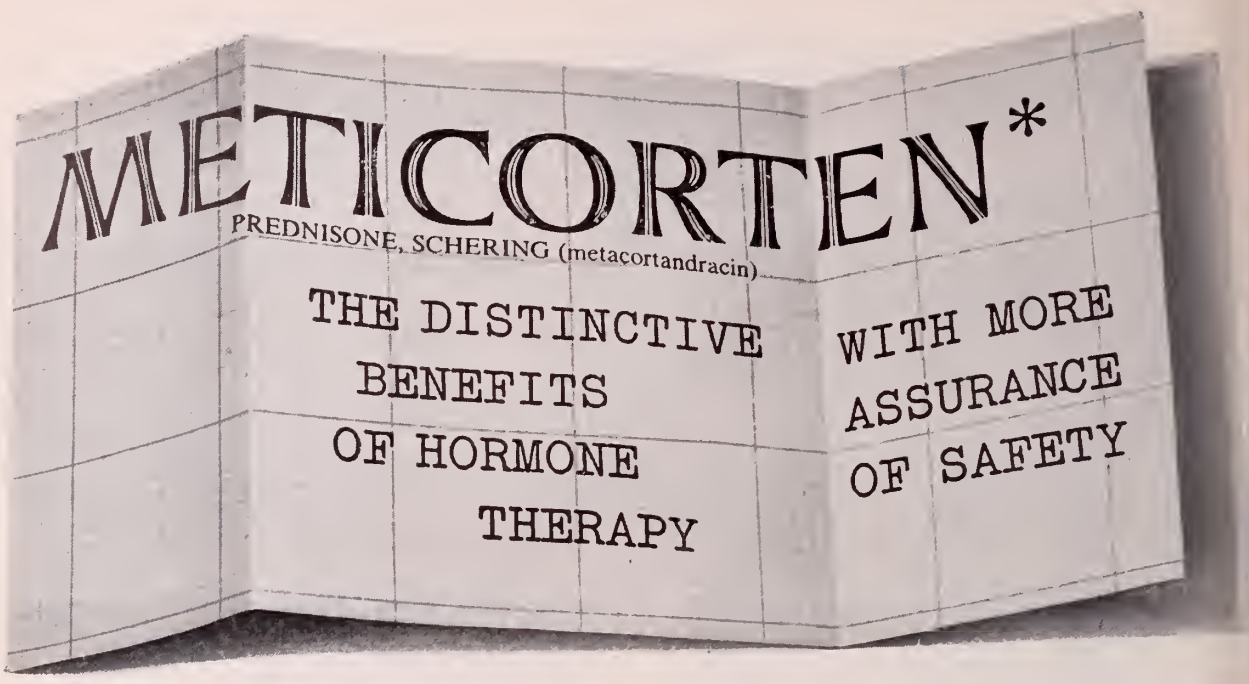
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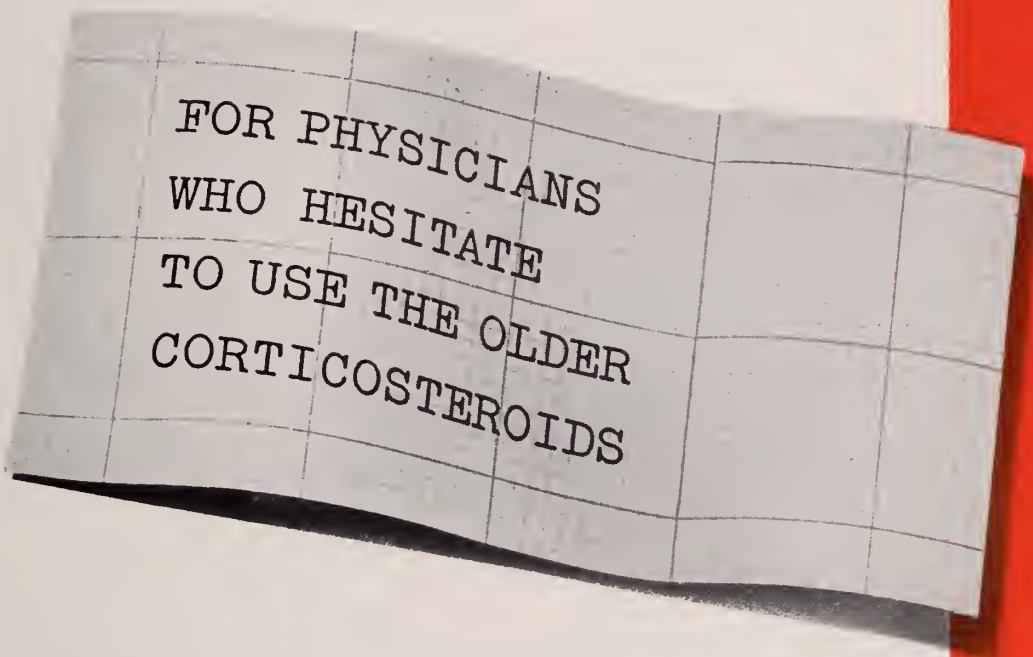
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OBITUARIES

Leo Honigsberg

Dr. Leo Honigsberg of Miami Beach died on July 6, 1955. He was 52 years of age.

A native of New York City, Dr. Honigsberg was born on Oct. 8, 1902. He received his premedical training at New York University and was awarded the degree of Doctor of Medicine by Columbia University College of Physicians and Surgeons in 1928. After serving an internship at Jackson Memorial Hospital in Miami, he entered the private practice of medicine in New York City.

In 1938, Dr. Honigsberg returned to Florida to practice in Miami Beach. With his brother, Dr. Alvin Honigsberg, he maintained offices in Miami Beach and Miami and operated the North Miami Medical Clinic. He was boxing commission physician in Miami Beach from 1942 until 1953 and police surgeon for the North Miami Beach police department from 1949 until his death. He was on the staff of St. Francis Hospital. A member of Miami Beach Elks Lodge 1601, he was also a member of the Civic League of Miami Beach.

Since 1941 Dr. Honigsberg had held membership in the Dade County Medical Association and the Florida Medical Association. In addition, he was a member of the American Medical Association.

The widow, Mrs. Honora Honigsberg, survives. Also surviving are a daughter, Kathleen; a son, Bradford; a sister, Dorothy; and his brother and associate, Dr. Honigsberg.

Edgar Peters

Dr. Edgar Peters of Miami died on July 16, 1955, after a long illness. He was 69 years of age. Interment took place in the family plot in the Miami City Cemetery.

A native Floridian, Dr. Peters was born Nov. 6, 1885, in Lady Lake and came to Miami in 1896 from Leesburg. He received his medical training at the Atlanta Medical College, later Emory University School of Medicine, and was awarded the degree of Doctor of Medicine in 1911. Entering the practice of medicine at Dania, he remained there one year and then moved to Miami in 1912. He completed a graduate course in genitourinary diseases at Tulane University of Louisiana School of Medicine in New Orleans and was the first physician in the Miami area to use a cystoscope. Later he engaged in graduate study in surgery at Cook County Hospital in Chicago and New York Polyclinic Hospital in New York City, and eventually confined his practice to that specialty.

Early in his Miami practice, Dr. Peters attracted the attention of Dr. James M. Jackson, who took great interest in him, and he assisted Dr. Jackson in all of his surgical work. He enjoyed the distinction of being the first health officer for the City of Miami, a post he held from 1912 to 1915. He engaged in active practice in Miami from 1912 to 1948, when he retired because of failing health. He served as attending physician on the Surgical Staff at Jackson Memorial Hospital from 1922 to 1952. Locally, he

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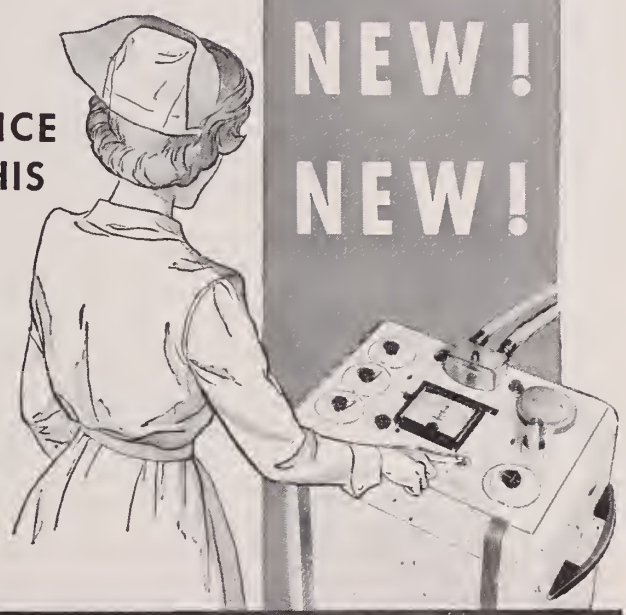
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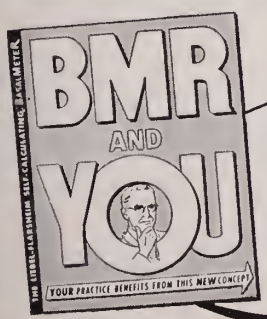
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was a Mason and a member of the Mahi Temple Shrine, and was also a member of the Elks Lodge.

Dr. Peters was the fifth member of the Dade County Medical Association and served as its president in 1915. A life member of the Florida Medical Association with honorary status since his retirement, he had been affiliated with the Association for 44 years. He also held membership in the American Medical Association and his specialty societies.

Surviving are the widow, Mrs. Ethel Peters; one daughter, Mrs. Leola Edwards, the wife of Dr. Howard Edwards; and two grandsons, all of Miami. Three brothers also survive, Hugh Peters Sr., Dade County commissioner, and Arthur Peters, both of Miami, and James Peters, of Peters, Fla.; and one sister, Mrs. Mattie Cooper, also of Miami.

Michael Price DeBoe

Dr. Michael Price DeBoe of Miami died at the Veterans Administration Hospital in Coral Gables on June 28, 1955, following a heart attack. He was 69 years of age. Interment took place in Key West.

Dr. DeBoe was born on his family's ancestral Goose Creek plantation in Bedford County, Virginia, on Nov. 29, 1885. He was educated in his native state and in 1908 was awarded the degree of Doctor of Medicine by the University College of Medicine in Richmond. During World War I he served as commanding officer of the medical department at the Key West Naval Base and during the 1918 influenza epidemic developed a treatment for influenza-pneumonia which was credited with saving many lives. Also, he was first to provide the early type of planes with equipment to render first aid treatment to injured personnel before evacuation.

After the war Dr. DeBoe practiced in Key West for four years before locating permanently in Miami in 1924. His specialty was ophthalmology and otolaryngology, and he rapidly became a leader in his chosen field. He was emeritus chief of staff of the department of ophthalmology and otolaryngology at Jackson Memorial Hospital at the time of his death. He was a Mason and a member of the Coral Gables American Legion Post.

Recently Dr. DeBoe became an honorary life member of the Dade County Medical Association. He was a life member of the Florida Med-

(Continued on page 422)



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2. Tyson, T. L., *J. Invest. Dermat.* 14:323, May 1950.

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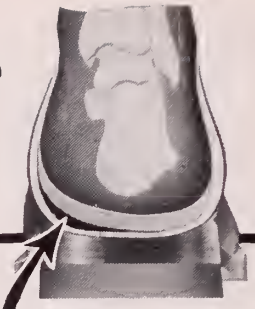
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(Continued from page 416)

ical Association, with which he had been affiliated since 1914, and was a member of the American Medical Association and the Southern Medical Association. He was a senior fellow of the American College of Surgeons and the American Academy of Ophthalmology and Otolaryngology and also held membership in the Florida Society of Ophthalmology and Otolaryngology. He made notable contributions to the scientific literature of his specialty.

Surviving is the widow, Mrs. Mizpah Otto DeBoe, of Miami.

BOOKS RECEIVED

Should the Patient Know the Truth? A Response of Physicians, Nurses, Clergymen and Lawyers. Edited by Samuel Standard, M.D., and Helmuth Nathan, M.D. Pp. 160. Price, $3.00, hard cover; $2.00, soft cover. New York, Springer Publishing Company, Inc., 1955.

To get at the core of the problem posed by its title, this book was written by 24 authors — surgeons, internists, psychiatrists; nurses active in various fields; clergymen representing different faiths; and experts in law. The opinions they express and the answers they give have grown from thousands and thousands of experiences with sick persons to whom it mattered whether or not they knew the truth. In addition, many, many patients are silent contributors to the ideas and conclusions gathered in the book, and the opinions of some patients are stated directly. Discussed also is the often difficult part played by the families of the patient, in the light of its importance to the patient, to themselves, and to nurses and doctors.

The book's question embraces a "doctor's dilemma" infinitely more common than Shaw's. Cancer and heart disease alone make the question a universal one. The doctor, ethically bound to do everything in his power to help his patient, is bound also to keep away a truth that will harm the patient, make him feel worse, or hinder his recovery. When the doctor prescribes a course of half truth or untruth, the nurses and the patient's family are caught in the same conflict.

It is the patient's well-being that counts; his needs and wants come first — his wish to be told or spared the truth. The book is a challenge to recognize, respect and accept the patient's feeling, different as they might be from one's own. The authors give specific guidance for many typical situations as they occur in their particular fields of medicine, surgery, or nursing; how they tell the truth and how they are timing the telling; when they may tell only part of the truth, the good part; why they choose evasion of the truth, how they prepare for it and carry it through.

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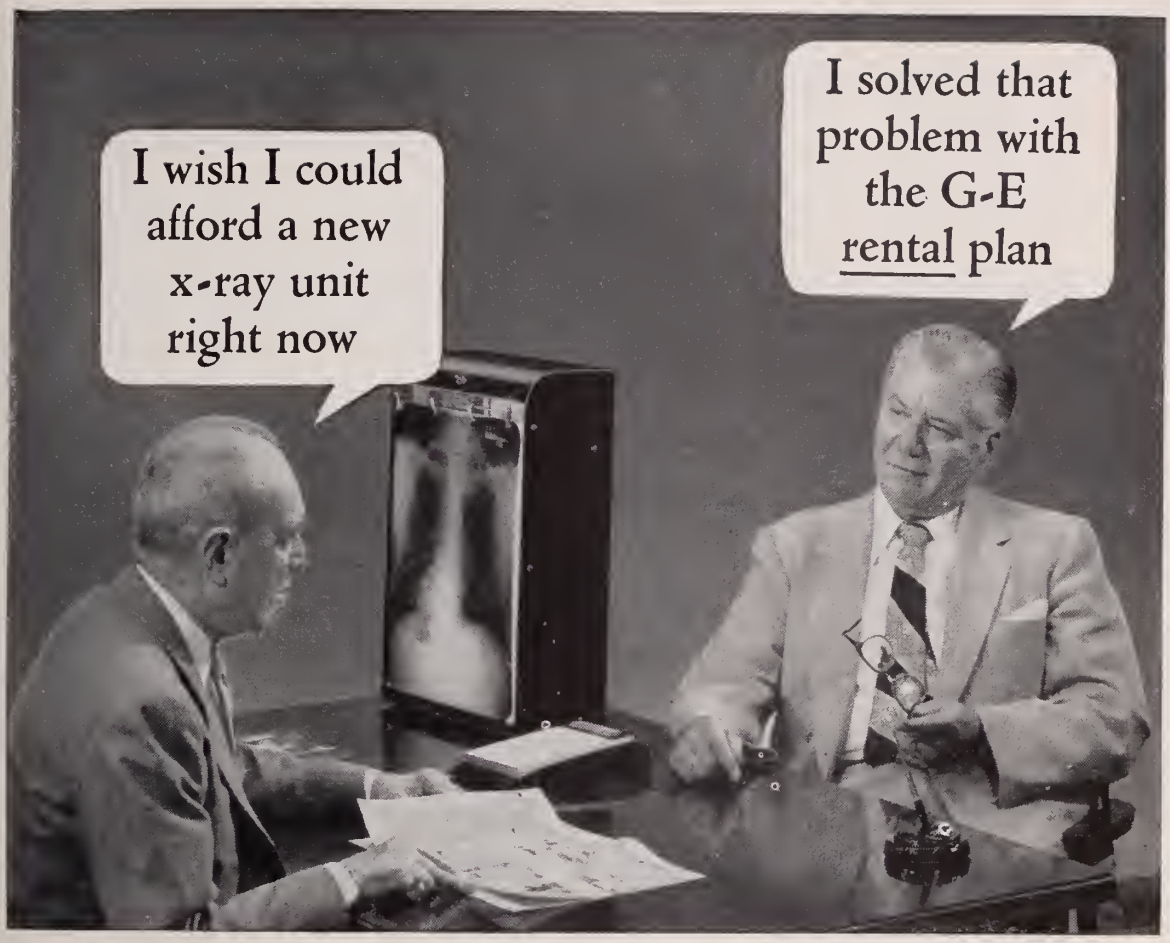
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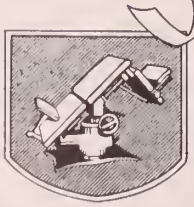
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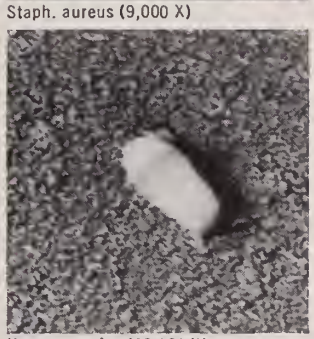
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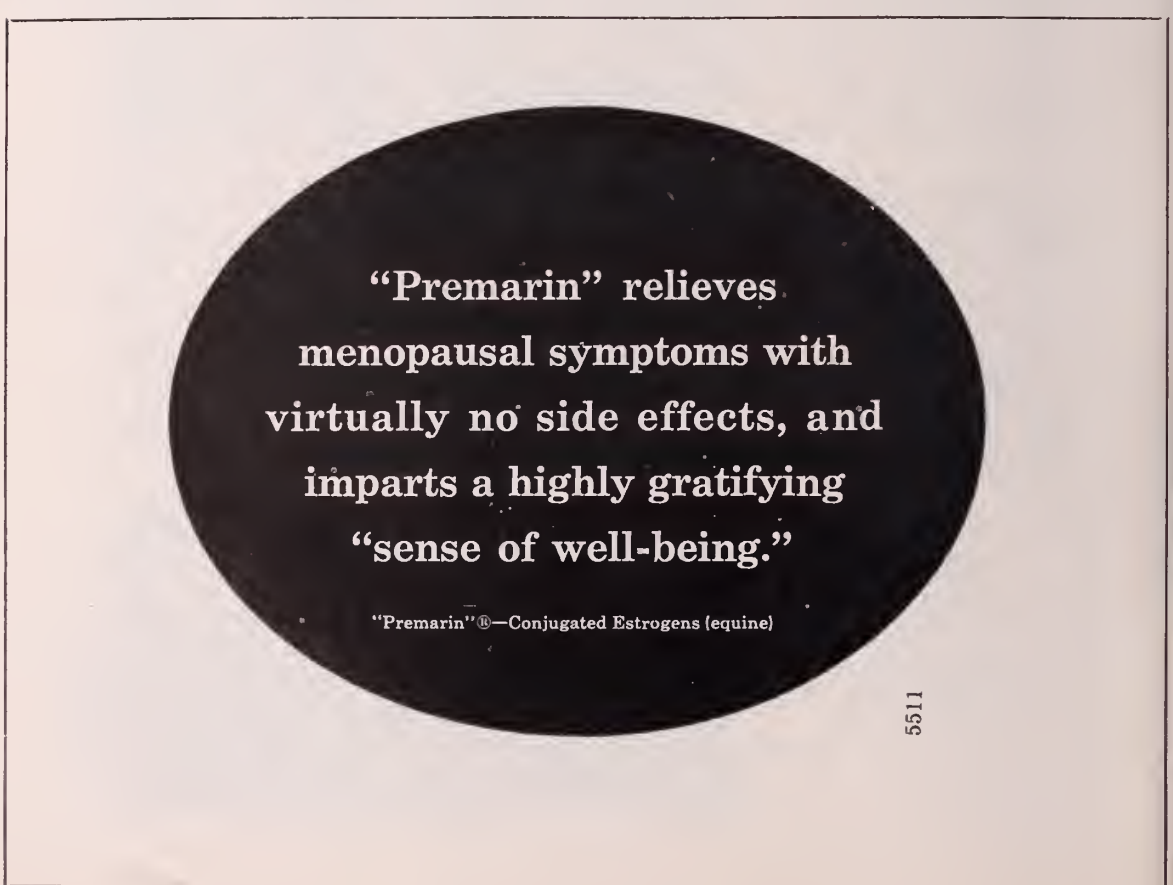
Wish You, Too, Could Have Been There, Doctors!

I have just arrived home from the Ponte Vedra Inn and am still so breathless about what happened there on September 28-29 that I just have to write about it right away.

Doctors, I am sorry more of you can't come to our state auxiliary meetings to find out what goes on in your auxiliary and how your wives carry on the auxiliary business, which after all, is your business too. Had you been with us at Ponte Vedra, I am sure you would have, as did those doctors who were there, gone away saying, "This is one of the finest things that has ever been put on in Florida for medicine."

Your auxiliary has grown up, has become of age and is showing its adult abilities in the participation of its members in the state activities as well as those of the component auxiliaries.

More than 75 members of the state auxiliary were present for the board meeting on the afternoon of September 28th which opened our session. The business was carried out speedily, but not so speedily that everyone present didn't have a chance to express herself and to bring before the board the business that was at hand. Following the board meeting, a dinner was held with a social



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hour prior to it at which all the women had a chance to talk with friends they hadn't seen since last April in St. Petersburg. The morning of September 29th brought forth our biggest and by far our best conference of the Auxiliary history. This conference is designed for county presidents, county presidents-elect and state chairmen. It was set up on the panel plan of presentation with guest speakers for some panels. Time was allowed for questions and answers and for exchange of ideas among the various county representatives. Space does not allow the total program and the names of those participating to be printed here.

It came as a surprise to many of us who have been told that there is so little talent — this when we talk about activities to the group — to find that it was just their modesty speaking. From our county auxiliaries more than 30 women participated in the various panels on Program, Public Relations, Legislation, American Medical Education Foundation, Nurse Recruitment, Civil Defense and Mental Health. All those present were more than aware of the vast amount of talent and knowledge present in our county auxiliaries and everyone obtained the idea that in the Florida Auxiliary "Success Unlimited," the keynote speech given by Mr. M. I. Clements, vice-president of the Graham Jones Paper Company, was not only appropriate but was an attainable goal for us.

The Florida Auxiliary is well aware that without the fine cooperation of the Managing Director, Mr. Ernest Gibson, the Assistant Managing Director, Mr. Harold Parham, the office staff of the Florida Medical Association and the interest, sympathetic understanding and help of the Florida Medical Association officers and board of governors, our growth and progress would not have been so fast nor as great and, in the instance of this conference, much of the material provided and the help received would not have been there. It is therefore hoped that all these above and especially Dr. Samuel M. Day, Dr. Edward Jelks, Mr. Gibson and Mr. Parham will accept our grateful thanks for their help and participation and that they will know as well as will all members of the Florida Medical Association, that our constant goal for "Success Unlimited" is to be of the greatest service to the Florida Medical Association. We are sorry, doctors, that all of you couldn't have been with us for we firmly believe that with the excellent program set up by Mrs. Samuel S. Lombardo, our auxiliary state president, each one of you would have received great benefit too.

Mrs. Richard F. Stover



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These good foods can be made even better—

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Although these "do's" list only the more familiar vitamins and minerals, the trace elements and other micronutrients are no less important. And a varied diet will help your patient get the vital body regulators he needs.

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The organisms commonly involved in

Bronchiectasis



Staph. aureus (9,000X)



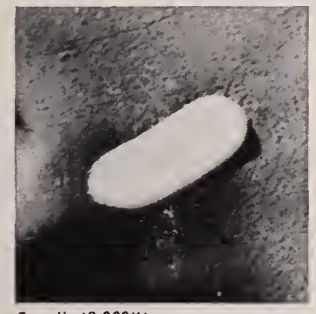
Strep. pyogenes (8,500X)



Strep. viridans (9,000X)



Strep. faecalis (10,000X)



E. coli (8,000X)



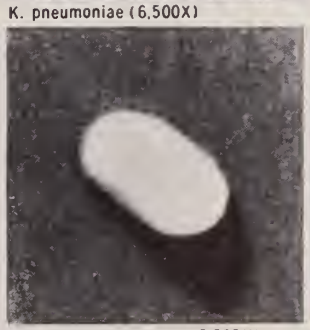
K. pneumoniae (6,500X)



D. pneumoniae (10,000X)



H. influenzae (16,000X)



Aerobacter aerogenes (12,500X)

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ELECTRON MICROGRAPHS

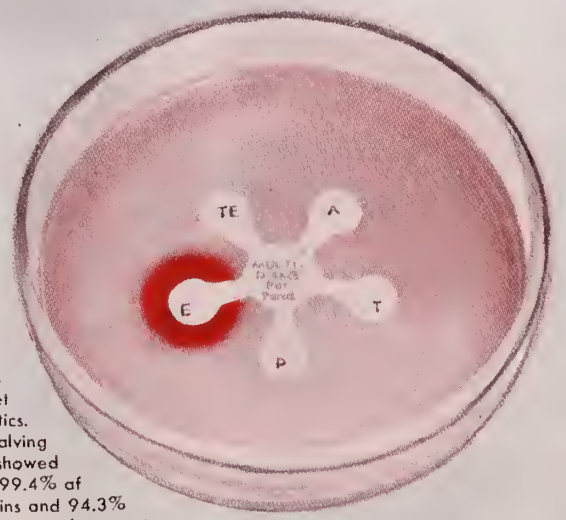
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1. Eisenberg, et al., Antib. & Chemo., 3:1026-1028, Oct., 1953.

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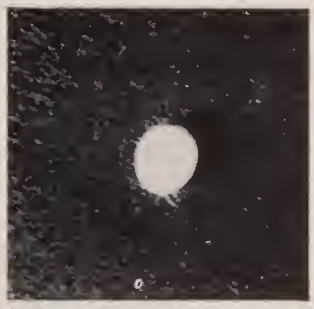
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The organisms commonly involved in

Acute Pharyngitis



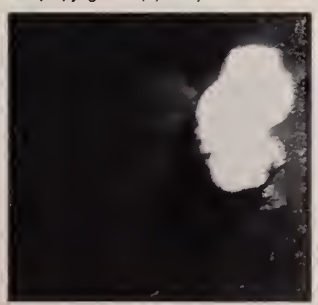
Strep. pyogenes (8,500X)



Staph. aureus (9,000X)



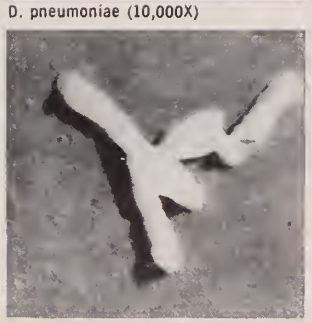
D. pneumoniae (10,000X)



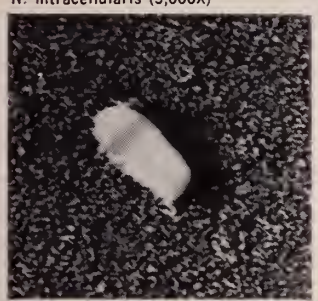
N. intracellularis (5,000X)



H. influenzae (16,000X)



C. diphtheriae (6,000X)



K. pneumoniae (13,000X)

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ELECTRON
MICROGRAPHS

***All* of them are included in the more than 30 organisms susceptible to broad-spectrum**

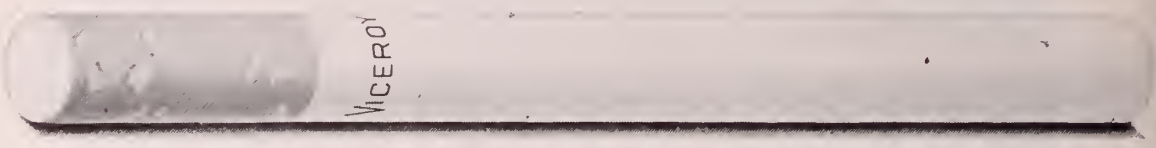
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VOLUME XLII
NUMBER 5

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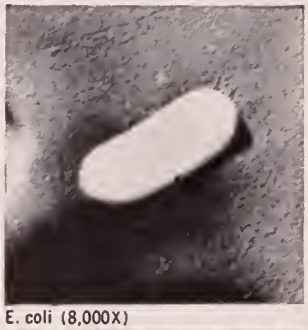
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The organisms commonly involved in

Pyelitis



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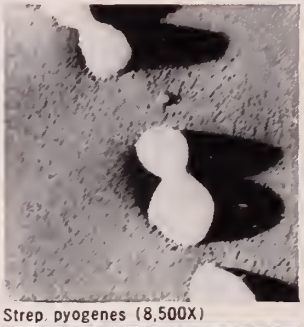
Aerobacter aerogenes (12,500X)



Salmonella paratyphi A (8,000X)



Salmonella paratyphi B (6,500X)



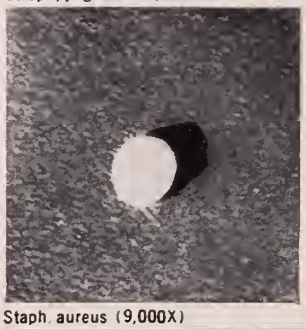
Strep. pyogenes (8,500X)



Strep. faecalis (10,000X)



Strep. viridans (9,000X)



Staph. aureus (9,000X)

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There's A Sparkle to A Glass of Wine

—That puts an answering sparkle into the eyes and appetites of your geriatric, post-surgical, sick and convalescent patients.

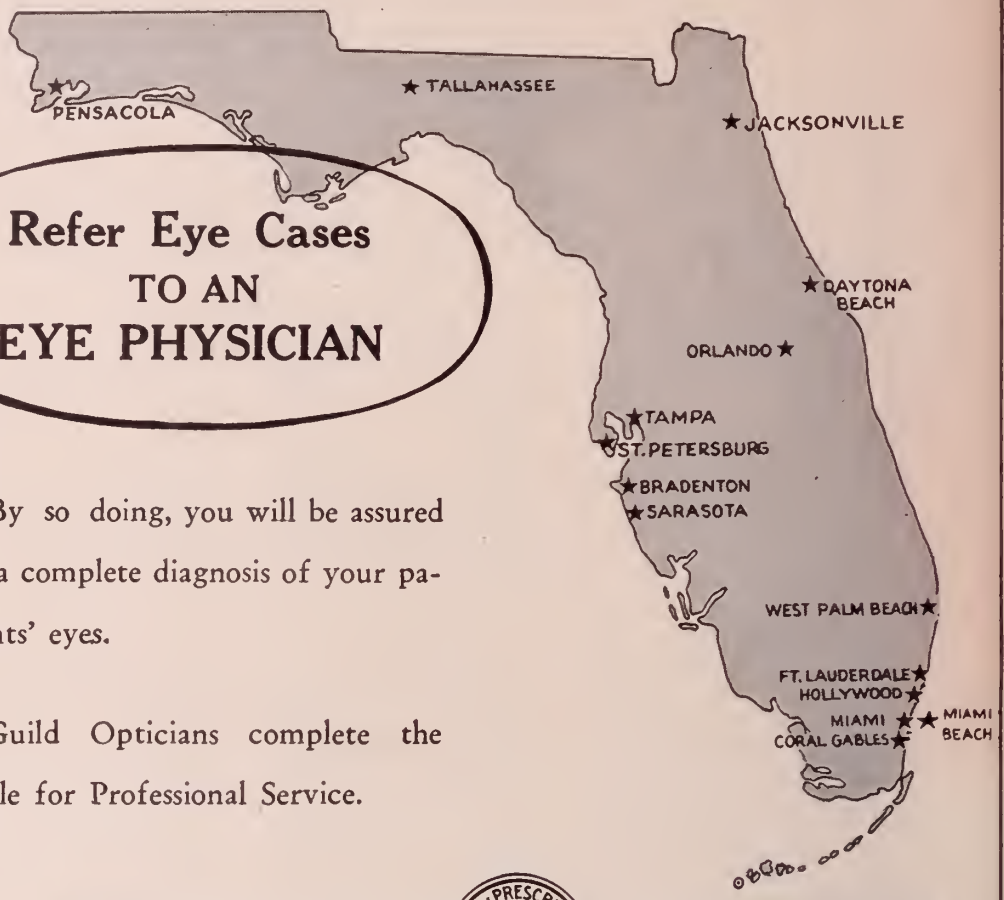
A glass of Port, Sherry, Burgundy, Rhine Wine—whatever taste pleases your patient—can do wonders to add zest and bouquet to meals, even when appetite is at low ebb.

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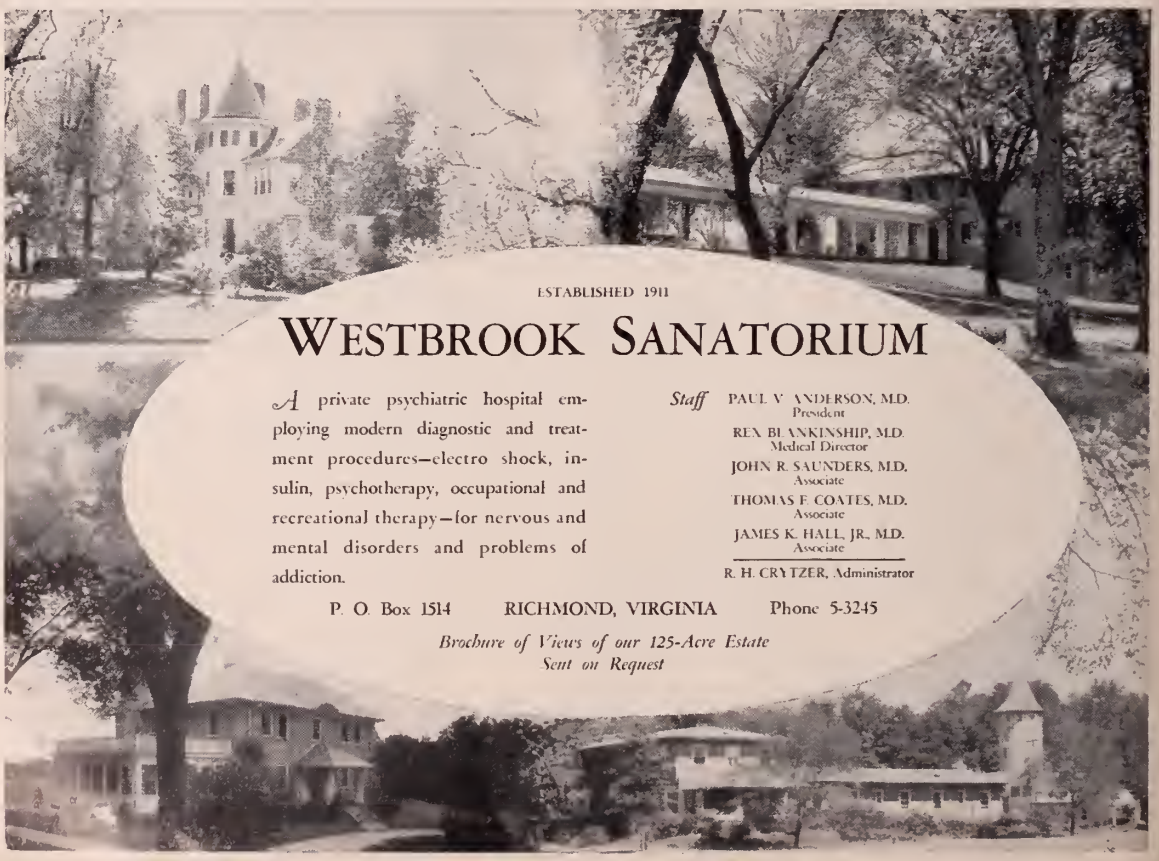
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da Medical Districts	Ralph W. Jack, Miami	Council Chairman	
Northwest	William P. Hixon, Pensacola	Walter J. Baker, Foley	Tallahassee
Northeast	Henry J. Babers Jr., Gainesville	Charles L. Park Sr., Sanford	Ocala
Southwest	C. Frank Chunn, Tampa	James R. Boulware Jr., Lakeland	Tampa
Southeast	James R. Sory, West Palm Beach	Ralph S. Sappenfield, Miami	West Palm Beach
la Specialty Societies			
emy of General Practice	Frank T. Linz, Tampa	James B. Hodge Jr., Tampa	
gy Society	W. Ambrose McGee, W. P. Bch	Norris M. Beasley, Ft. Lauderdale	Miami Beach, May, 13-16 '56
hesiologists, Soc. of	Wayland T. Coppedge Jr., Jax	William H. Houston, Jacksonville	" " " "
Phys., Am. Coll., Fla. Chap	Hawley H. Seiler, Tampa	William L. Potts, Lantana	" " " "
and Syph., Assn. of	Joseph L. Hundley, Orlando	Kenneth J. Weiler, St. Petersburg	" " " "
h Officers' Society	Clarence L. Brumback, W. P. Bch	Lorenzo L. Parks, Jacksonville	" " " "
trial and Railway Surgeons	Frank L. Fort, Jacksonville	John H. Mitchell, Jacksonville	" " " "
ology & Psychiatry	Edward H. Williams, Miami	J. Robert Campbell, Tampa	" " " "
nd Gynec. Society	J. Champneys Taylor, J'sonville	Reuben B. Chrisman Jr., Miami	" " " "
nal. & Otol., Soc. of	Charles W. Boyd, Jacksonville	Kenneth S. Whitmer, Miami	" " " "
pedic Society	Edward W. Cullipher, Miami	Robert P. Keiser, Coral Gables	" " " "
ologists, Society of	Millard B. White, Sarasota	Wray D. Storey, Tampa	" " " "
tric Society	Lewis T. Corum, Tampa	Joel V. McCall Jr., Daytona Beach	" " " "
ologic Society	Thomas F. Nelson, Tampa	George Williams Jr., Miami	" " " "
ological Society	Hugh G. Reaves, Sarasota	Donald H. Gahagen, Ft. Lauderdale	" " " "
ons, Am. Coll., Fla. Chapter	Joseph S. Stewart, Miami	C. Frank Chunn, Tampa	" " " "
gical Society	David W. Goddard, Daytona Bch	W. Dotson Wells, Fort Lauderdale	" " " "
la—			
Bic Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, Nov. 5, '55
Blood Banks, Association	Louis E. Pohlman, Orlando	Mrs. Estelle Lieberman, W. P. Bch.	
Red Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	St. Petersburg, Dec. 6, '55
Blue Shield of Florida, Inc.	Russell B. Carson, Ft. Lauderdale	John T. Stage, Jacksonville	
Cancer Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	Miami Beach, May 13, '56
Clinical Diabetes Assn.	Sidney Davidson, Lake Worth	Edward R. Smith, Jacksonville	
Dental Society, State	T. A. Price, D.D.S., Miami	W. A. Buhner, D.D.S., Daytona Bch.	Miami Beach, May 28-30 '56
Heart Association	Victor H. Kugel, Miami Beach	Edwin P. Preston, Miami	
Hospital Association	Mr. Pat N. Groner, Pensacola	Mr. Steve F. McCrimmon, C. Gbls.	St. Petersburg, Dec. 8-9, '55
Medical Examining Board	Morris B. Seltzer, Daytona Bch.	Homer L. Pearson Jr., Miami	Miami Beach, Nov. 20-22, '55
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
Nurse Anesthetists, Fla. Assn.	Miss Dorothy Jackson, C. Gables	Mrs. Lulla F. Bryan, Miami	St. Petersburg, Dec. 6-8, '55
Nurses Association, State	Martha Wolfe R.N., Coral Gables	Agnes Anderson, R.N., Orlando	Daytona Beach, Nov. 28-30, '55
Pharmaceutical Assoc., State	Miss Frances Walpole, Sarasota	Mr. R. Q. Richards, Ft. Myers	
Public Health Association	Mr. J. A. Mulrennan, Jacksonville	Mr. Fred B. Ragland, Jacksonville	
Trudeau Society	Harold W. Johnston, Orlando	Howard M. DuBose, Lakeland	
Tuberculosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mr. Ernest L. Abel, W. Palm Beach	
Woman's Auxiliary	Mrs. Samuel Lombardo, J'sonville	Mrs. Leffie M. Carlton Jr., Tampa	Miami Beach, May 13-16, '56
ican Medical Association	Elmer Hess, Erie, Pa.	Geo. F. Lull, Chicago	Chicago, June 11-15, '56
A.M.A. Clinical Session	Elmer Hess, Erie, Pa.	Geo. F. Lull, Chicago	Boston, Nov. 29-Dec. 2, '55
ern Medical Association	Robt. L. Sanders, Memphis, Tenn.	Mr. V. O. Foster, Birmingham	Houston, Nov. 14-17, '55
ina Medical Association	F. L. Chenault, Decatur	Douglas L. Cannon, Montgomery	Birmingham, Apr. 19-21, '56
ia, Medical Assn. of	H. Dawson Allen Jr., Milledgeville	David Henry Poer, Atlanta	Atlanta, May 13-16, '56
Hospital Conference	Mr. D. O. McClusky Jr. Tuscaloosa, Ala.	Mr. Pat Groner, Pensacola	Miami Beach, Apr. 18-20, '56
astern Allergy Assn.	Ben Miller, Columbia, S. C.	Kath. B. MacInnis, Columbia, S.C.	Charlotte, N. C., Oct. 5-6, '56
astern, Am. Urological Assn.	Sidney Smith, Raleigh, N. C.	Robert F. Sharp, New Orleans	Hollywood, Mar. 25-29, '56
astern Surgical Congress	Donald S. Daniel, Richmond	B. T. Beasley, Atlanta	Richmond, Mar. 12-15, '56
Coast Clinical Society	Walter C. Payne Sr., Pensacola	Barkley Beidleman, Pensacola	

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SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Total Members
Alachua	Edwin H. Andrews, Gainesville	Henry S. Blank, Gainesville	2nd Tues.	55
***Bradford, Gilchrist, Union**				
Bay	William F. Humphreys Jr., Panama City	Roderick C. Webb, Panama City	1st Tues.	28
Brevard	Lee Rogers Jr., Cocoa	Charles E. Russell, Cocoa	2nd Tues.	38
Broward	Ernest E. Serrano, Hollywood	Alfred E. Cronkite, Fort Lauderdale	4th Tues.	121
Columbia	Robert B. Harkness, Lake City	Thomas H. Bates, Lake City	1st Mon.	11
***Baker**				
Dade	L. Washington Dowlen, Miami	Robert F. Dickey, Miami	1st Tues	735
DeSoto-Hardee-Highlands-Glades	Gordon H. McSwain, Arcadia	Harold S. Agnew, Arcadia	1st Tues.	28
Duval	Raymond H. King, Jacksonville	Eugene M. Frame, Jacksonville	1st Tues.	299
***Clay**				
Escambia	George W. Morse, Pensacola	Paul F. Baranco, Pensacola	2nd Tues.	107
***Santa Rosa**				
Franklin-Gulf	Warren T. Weathington, Apalachicola	Joseph P. Hendrix, Port St. Joe	Last Wed.	6
Hillsborough	Frank S. Adamo, Tampa	Julien C. Pate Jr., Tampa	1st Tues.	193
Indian River	Kip G. Kelso, Vero Beach	Vernon L. Fromang, Vero Beach	2nd Tues.	9
Jackson-Calhoun	Henry I. Langston, Marianna	Francis M. Watson, Marianna	Quarterly	17
Lake	Louis R. Bowen, Eustis	J. Basil Hall, Tavares	1st Wed.	29
***Sumter**				
Lee-Charlotte-Collier-Hendry	Baker Whisnant, Fort Myers	James L. Bradley, Fort Myers	3rd Mon.	38
Leon-Gadsden-Liberty-Wakulla-Jefferson	William L. Hunter, Monticello	Odis G. Kendrick Jr., Tallahassee	Quarterly	67
Madison	A. Franklin Harrison, Madison	Wallace E. Winter, Madison		8
Manatee	Marjorie L. Warner, Bradenton	Harvey C. Pauley Jr., Bradenton	2nd Tues.	31
Marion	William H. Turnley, Ocala	Bertrand F. Drake, Dunnellon	3rd Tues.	31
***Levy**				
Monroe	Ralph Herz, Key West	William R. Ploss, Key West	1st Thurs.	15
Nassau	David G. Humphreys, Fernandina Beach	John W. McClane, Fernandina Beach	Last Fri.	11
Orange	Don C. Robertson, Orlando	Walter A. Derrick, Orlando	3rd Wed.	192
***Osceola**				
Palm Beach	Edwin W. Brown, West Palm Beach	James R. Anderson, West Palm Beach	4th Mon.	148
Pasco-Hernando-Citrus	Harry G. Brownlee, Zephyrhills	W. Wardlaw Jones, Dade City	2nd Thurs	17
Pinellas	Clyde O. Anderson, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	225
Polk	Samuel J. Clark, Lakeland	Marion W. Hester, Lakeland	2nd Wed.	102
Putnam	Grover C. Collins, Palatka	Alfred P. Peretti, Palatka	2nd Tues.	10
St. Johns	George C. Hopkins, St. Augustine	Reuben J. Plant Jr., St. Augustine	3rd Tues.	21
St. Lucie-Okeechobee-Martin	Henry E. Branca, Fort Pierce	Adrian M. Sample, Fort Pierce	3rd Thurs.	24
Sarasota	Melvin M. Simmons, Sarasota	Andrew J. Jesacher, Sarasota	2nd Tues.	58
Seminole	John M. Morgan, Sanford	Terry Bird, Sanford	2nd Tues.	20
Suwannee	William P. Blackmon, Jasper	Hiram B. Curry, Jasper	1st Sat.	12
***Hamilton, Lafayette**				
Taylor	John H. Parker Jr., Perry	Ralph J. Greene, Perry	Last Fri.	5
***Dixie**				
Volusia	Robert L. Miller, Daytona Beach	Achille A. Monaco, Daytona Beach	2nd Tues.	83
***Flagler**				
Walton-Okaloosa	Richard H. Lee, Crestview	Frederic E. Caldwell, Fort Walton Beach	3rd Tues	20
Washington-Holmes	L. H. Paul, Bonifay	Bayllye W. Dalton, Chipley		5
			Total	2,819

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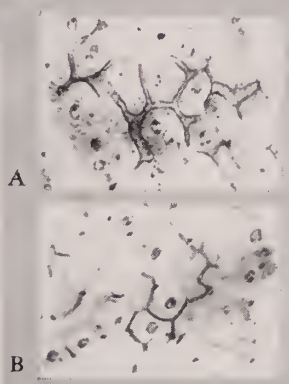
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(1) Clara, M.: Med. Monatsschr. 7:356, 1953. (2) Brauer, R. W., and Pessotti, R. L.: Science *115*:142, 1952. (3) Schwimmer, D.; Boyd, L. J., and Rubin, S. H.: Bull. New York M. Coll. *16*:102, 1953.

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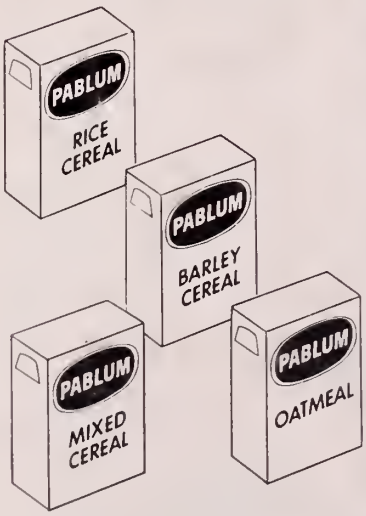


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Mark E. Adams

Cat Scratch Disease
Maurice Blinski and Harry D. L. Kaye

Clinical Observations on Histamine
Clarence Bernstein and Solomon D. Klotz

Intracranial Aneurysms
C. Ashley Bird

Lymphosarcoma of the Tonsil
Thomas M. Edwards and Collin F. Baker Jr.

A Physician's Prayer
Frank G. Slaughter

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References: (1) Spink, W. W.: *Arch. Int. Med.* 94:167, 1954. (2) Finland, M.: *J.A.M.A.* 158:188, 1955. (3) Tebrock, H. E., & Young, W. N.: *New York J. Med.* 55:1159, 1955. (4) LeMaistre, C.: *M. Clin. North America* 39:899, 1955. (5) Kagan, B. M.: *J.M.A. Georgia* 44:210, 1955. (6) Branch, A.; Starkey, D. H.; Rodgers, K. C., & Power, E. E., *in* Welch, H., & Marti-Ibañez, F.: Antibiotics Annual, 1954-1955, New York, Medical Encyclopedia, Inc., 1955, p. 1125. (7) Kutscher, A. H.; Seguin, L.; Lewis, S.; Piro, J. D.; Zegarelli, E. V.; Rankow, R., & Segall, R.: *Antibiotics & Chemother.* 4:1023, 1954. (8) Weil, A. J., & Stempel, B.: *Antibiotic Med.* 1:319, 1955. (9) Jones, C. P.; Carter, B.; Thomas, W. L., & Creadick, R. N.: *Obst. & Gynec.* 5:365, 1955.

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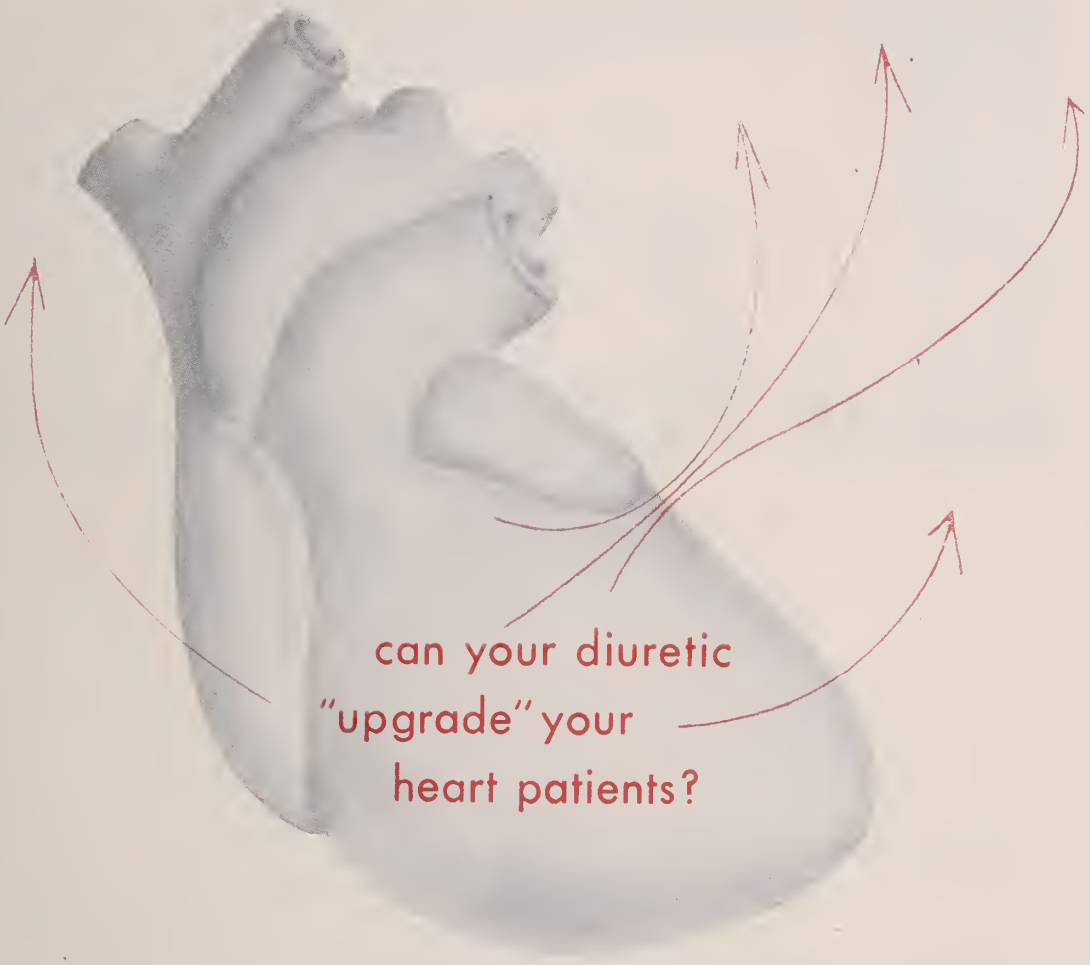
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*Georges Ray, Vins de France, Paris, University Press, 1946 (p. 75).

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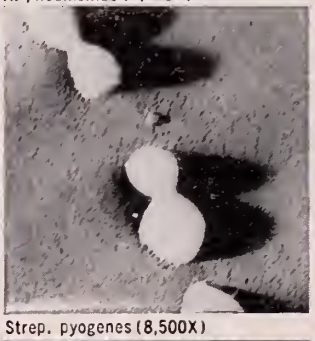
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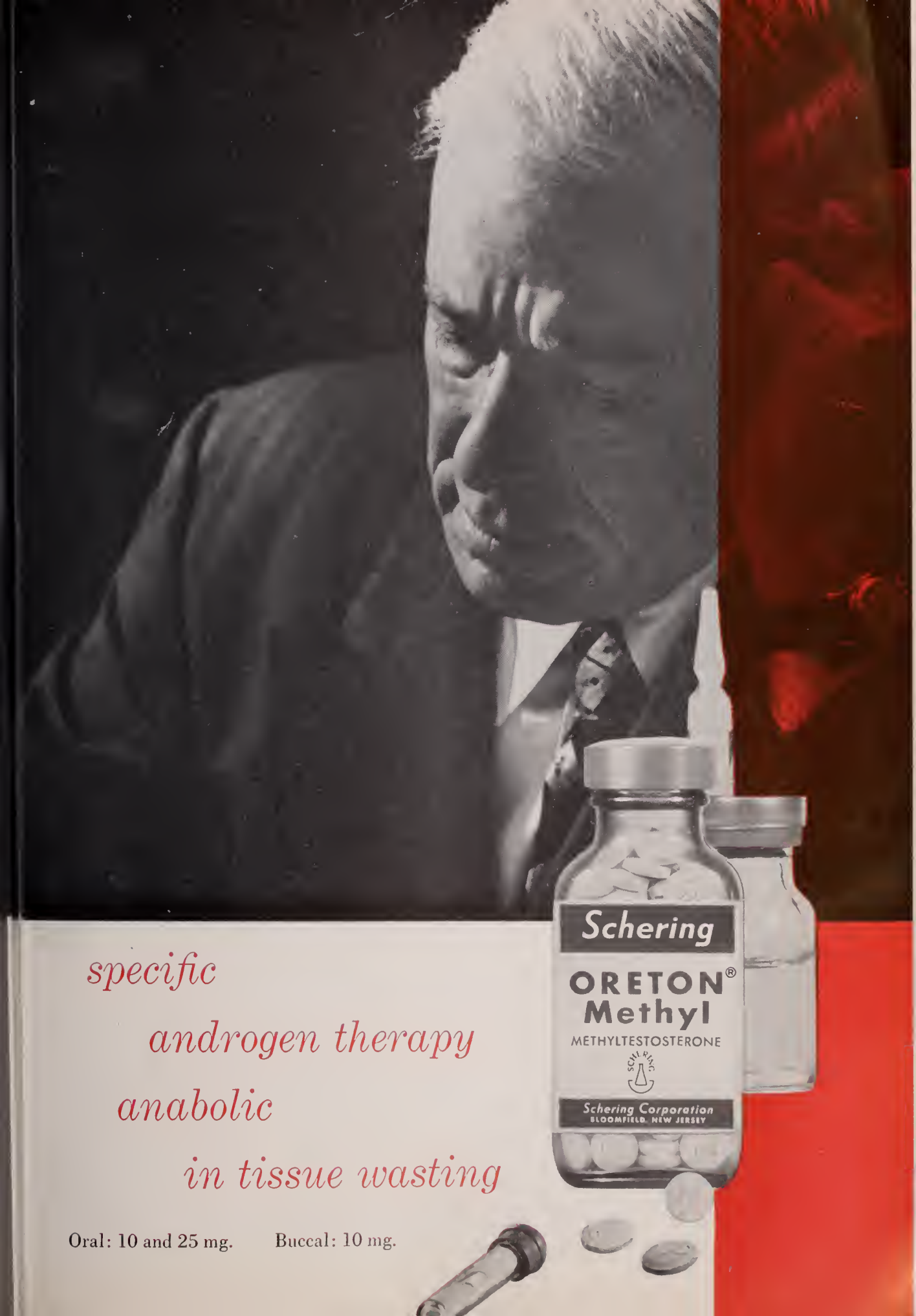
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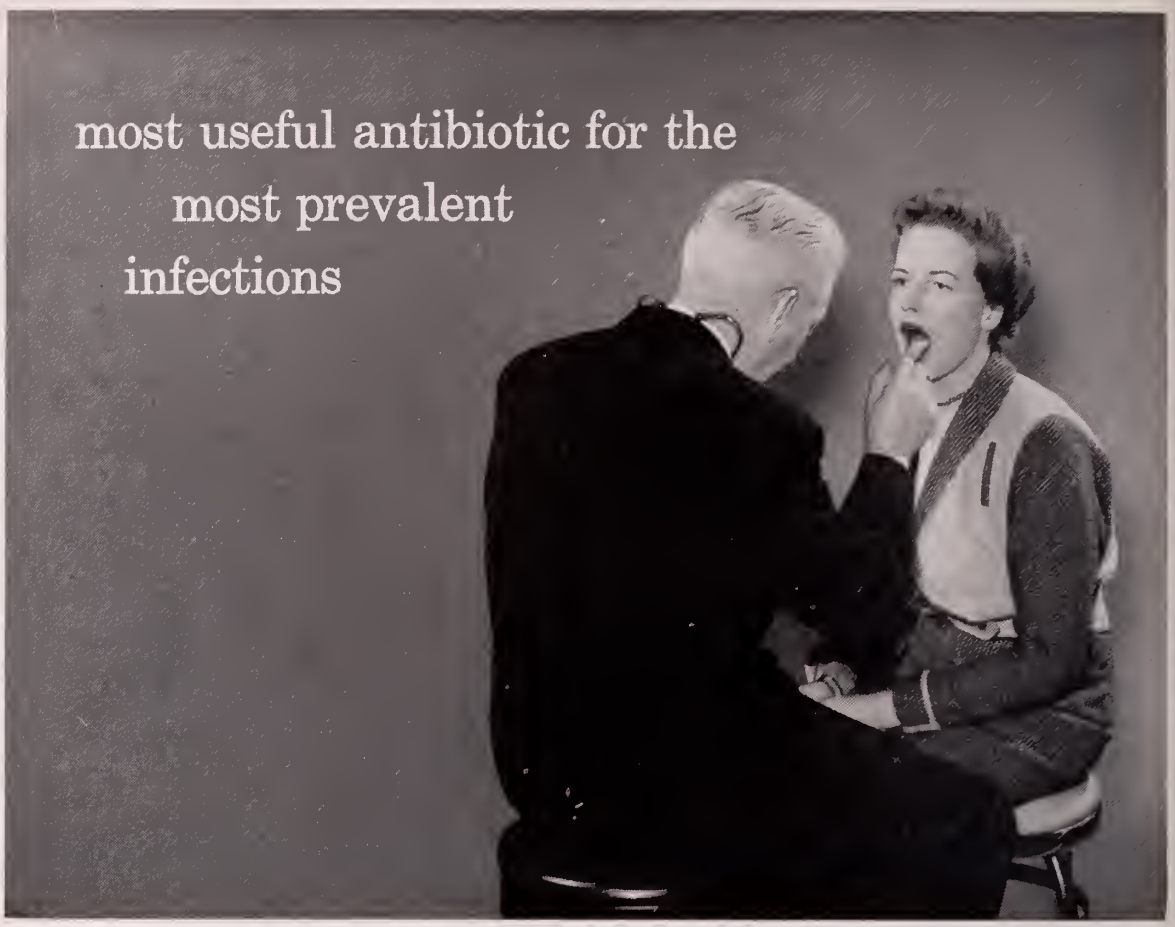
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The State Narcotic Patient at the Florida State Prison

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RAIFORD

Narcotic addicts at the Florida State Prison consist of two groups: first, the inmates who have been sentenced to terms of imprisonment; and second, the state narcotic patients. From the standpoint of treatment, the first group poses no problem; almost invariably the addict will have been confined in the county jail since his arrest, and throughout trial, so that usually complete withdrawal of the drug has been effected insofar as physiologic dependence is concerned. The second group, the state narcotic patients, are the ones with whom we are concerned here. Under Section 398.18 of the Florida statutes, these men and women are committed to the prison hospital as narcotic patients by the Circuit Courts ". . . until cured or free of the habit of using narcotic drugs . . ." Treatment, the statute goes on to say, ". . . shall be designed to rehabilitate and restore such persons to mental and physical health." No specified term of hospitalization is set forth; the committing judge may order the patient's discharge at his own discretion, or when the prison Superintendent and the Narcotic Director of the State Board of Health decide that ". . . the mental and physical condition of said narcotic patient is such as to entitle him to discharge."

Florida is unique among the states in having such statutory provisions for narcotic addicts. In the United States Public Health Service establishments at Lexington, Ky., and Fort Worth, Texas, voluntary patients and convict addicts are treated together, though the voluntary patient may be discharged at any time at his own request. In Florida, the noncriminal addict is committed to prison as a "patient."

Read before the Florida Health Officers' Society, Tenth Annual Meeting, St. Petersburg, April 4, 1955.

The Florida plan is theoretically sound; nevertheless, it is largely nullified by the realities of prison administration. At Raiford, the prison population is approximately 2,000; the usual state narcotic patient population is 10, which constitutes only one half of 1 per cent of the total. These few, however, require a disproportionate share of attention by the institution's officials and medical staff.

The prison hospital employs one full time medical officer; he is assisted by other part time physicians, and by four full time employees who handle x-ray, laboratory and outpatient departments, as well as nonmedical activities. None of these is highly trained in the technics of physiotherapy, psychotherapy, or occupational therapy. Hospital nurses and orderlies are prisoners, as are the clerical workers; most are untrained before arrival at the prison. Thus, with emergency and elective surgery, examinations, immunizations and classification of new prisoners, routine medical work of the wards, and the inevitable administrative duties, the physician finds little time to devote to the particular needs of the state narcotic patients.

During 1954, 20 state narcotic patients were committed to Raiford: 12 white men, 7 white women, and 1 Negro woman. The duration of hospitalization ranged from 47 days to six months, some patients being discharged by the courts despite the medical officer's recommendation for continued treatment.

Regimen for Narcotic Patients

The regimen for the narcotic patient at the prison hospital is similar to that ordered for patients in the United States Public Health Service institutions. The main hospital has 80 beds, the

tuberculosis annex 60, and the women's hospital, in another part of the prison, has 20. The average daily census of all is 110. Male narcotic patients are assigned to one ward in the main hospital, and contact with prisoners is kept to a minimum. Women narcotic patients must of necessity be placed in the one female ward, where association with hospitalized prisoners is unavoidable.

Rapid withdrawal therapy is prescribed for narcotic patients known to be currently addicted at the time of admission. The criterion is whether or not the patient has received narcotic drugs within five days prior to admission. Lacking definitive evidence to the contrary, it is assumed that the patient has not, and except as needed for medical emergencies, none is prescribed.

The minimum withdrawal period is arbitrarily set at 60 days, usually calculated from the date of admission. Most workers agree that 60 days after complete withdrawal of narcotics, physiologic dependence on drugs will be minimal. Other things being equal, the patient should be physically stable, and convalescence from withdrawal well advanced by that time. Psychic or emotional dependence on the drug may remain, of course, and efforts toward rehabilitation should be initiated.

Need for Psychiatric Guidance

In various studies addicts have been classified as to cause of addiction, but for practical purposes, it can be assumed that every addict has a basic personality defect from which the addiction stems. For this reason, psychiatric guidance is mandatory; almost never does a patient possess sufficient insight to recognize the defect in himself which led to the addiction. Many will refuse to try to gain such insight. Some therapists and custodial officers, and most addicts, say "once a junkie, always a junkie" and "there is no such thing as rehabilitation." A few idealists are diametrically opposed, and cling firmly to the idea of universal rehabilitation. Reality lies somewhere between these extremes, but only a psychotherapist of great skill can safely lead the patient in the rehabilitative process.

Here, then, is where the state prison hospital falls short of its function, assigned by law, in handling state narcotic patients. We can, and do, treat them medically and, if need be, surgically. Each patient is given a thorough admission examination and subsequent interval examinations as indicated. Every effort is made to correct physical defects, and from the physical standpoint, the end results have been good.

From a psychiatric standpoint, however, much is to be desired. The etiology of narcotic addiction is similar to that of alcoholism. In both diseases, the list of causative factors reads the same: tension, conflict, maladjustment, psychoneurosis or psychasthenia, all unsolved emotional problems. Methods of treatment are alike: withdrawal of the drug, followed by re-education and psychotherapeutic measures to rehabilitate the patient. With the limited personnel available at the state prison, and under present conditions, adequate psychotherapy for state narcotic patients is impossible of achievement. Because of space limitations, we are unable to separate patients who have completed the withdrawal phase from those who have not; nor is it possible to assign the patients to regular duties or supervised manual activities which would hold their interest. To do so would require three extra shifts of guards and matrons. We have attempted to set up a series of study assignment for each patient, using material from texts prescribed for enlisted personnel of the armed forces, but this is admittedly only a stopgap arrangement.

The conclusion is inescapable that these men and women, ordered hospitalized solely because of their addiction to drugs, are misfits in an exclusively penal institution. In such a situation, they constitute an essentially noncriminal nucleus surrounded by a sphere of criminality. The nature of the arrangement in which these patients are placed, and the dubious influences which they inevitably contact, present severe obstacles to the achievement of mental health. Further, it is questionable whether any prison the world over is ever completely free of the smuggling of contraband drugs. While patients and prisoners may safely and freely mingle in a hospital such as that at Lexington, it is obvious that they cannot be allowed to do so in a purely correctional institution.

Despite the questionable esteem in which narcotic addicts are sometimes held, considerable evidence shows them to be weak and dependent rather than vicious. They need supervision more than coercive repression, and the type of supervision needed by the addict differs widely from the custody which must be accorded the convicted criminal. It is the opinion of many authorities that the narcotic addict, as such, is no more criminal than the alcoholic addict, that for pur-

poses of hospitalization and treatment there should be little distinction between the two, and that treatment of either should be based on scientific rather than legal or emotional considerations.

It is not my purpose to criticize the legislative bodies, or the laws they enact. Nevertheless, the conviction is strong that Florida's state narcotic patients should, in justice to them and to the state, be treated in hospitals specifically designed for handling this type of patient, hospitals which have the medical, surgical, psychiatric and rehabilitative facilities which are needed, in other words, in the hospitals which are presently being established for the treatment of alcoholic patients.

Summary

In summary, at Raiford we give the state narcotic patient medical and surgical care, a good diet, and a limited opportunity to help himself during his brief stay. Because we have neither the facilities, the personnel, nor the time, we cannot give him psychiatric help, occupational therapy, or the ability to adjust to the trials and tribulations of everyday living, the very aids without which permanent cure is improbable.

We can only place him at the starting line. We cannot furnish the motive power.

Grateful acknowledgement is made to the Hon. L. F. Chapman, Superintendent, Florida State Prison, for permission to publish this information.

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Box 221.

Cat Scratch Disease with Lymphadenopathy In Mother and Child

Maurice Blinski, M.D.
Miami
and
Harry D. L. Kaye, M.D.
Coral Gables

In the differential diagnosis of lymphadenopathy, one must now consider cat scratch disease as a more frequent etiologic factor. Two cases of this disease from the same household involving different diagnostic and therapeutic approaches are here reported.

Report of Cases

Case 1.—G. D., aged 16 months, was first seen in the office on June 23, 1954, with the complaint of swollen gland of the right axilla. The temperature was 100 F. rectally. Examination revealed a walnut-sized, firm, nontender, axillary node, and three infected areas of the right thumb, interpreted as insect bites. The child was given parenteral and oral penicillin. During the next week, the adenopathy remained the same, the temperature ranged between 98 F. and 100.2F. rectally, the tonsils were hypertrophic, the pharynx was injected, and small shotty nodes were felt in the left axilla and both inguinal areas. A patch test gave negative results, and a blood count revealed red blood cells 4.5 million, hemoglobin 14.5 Gm., and white blood cells 12,300 with 73 lymphocytes, 26 segmented forms, and 1 stab form. A course of Terramycin was administered, and since the axillary adenopathy on the right side was still present on July 13, a biopsy and removal of the gland were performed. The axillary gland was surgically opened, drained and biopsied.

The pathologic report was: Aerobic and anaerobic cultures of pus were negative. Microscopic: Chronic inflammatory reaction.

Within one month the child made an uneventful recovery.

Case 2.—About three weeks later, Mrs. D., mother of G. D., was seen by one of us (H. K.). There was a history of four days' duration of, supposedly, an insect bite on the little finger of the left hand. The insect was never seen. The bite area consisted of a 4 mm. reddened papule with a darker red center, nonpruritic but tender. Within 24 hours there developed more pronounced pain and swelling of the left elbow, which was partially relieved by hot soaks and a sling.

On physical examination, the temperature was 99.2 F. In addition to the lesion of the left hand, there was a 10 by 8 by 3 cm. swelling over the left epitrochlear gland with overlying redness, three plus tender, but nonfluctuant and without restriction of motion of the elbow or shoulder. There was suggestive lymphangitis, and small (1 cm.) axillary glands were also palpable. Laboratory work revealed negative agglutinations, normal results of urinalysis and a blood count of hemoglobin 14.0 Gm., red blood cells 5.66 million, white blood cells 15,000, polymorphonuclear leukocytes 61, lymphocytes 25, monocytes 7 and eosinophils 7.

The patient was treated with hot soaks, rest, elevation and penicillin. Recovery was uneventful at the end of two weeks. There developed temporary fluctuation of the epitrochlear gland, which subsided spontaneously.

At this time a cat scratch fever test gave positive results. One month later the cat scratch fever antigen was injected into the infant, G. D., and a positive reaction was obtained. The mother admitted the presence of household cats, but could not recall definitely any bites or scratches from the cats.

Comment

We have presented 2 cases of cat scratch disease with different sites of adenopathy and different therapeutic approaches, one surgical and one nonsurgical.

Since the incidence of cat scratch disease has become more frequent, it behooves the internist, surgeon, general practitioner and pediatrician to consider cat scratch disease more commonly in differential diagnosis. Four cases were reported in Florida last year by DeVito,[1] who discussed the disease in some detail. In 3 of his cases the axillary nodes were involved and in 1 case the right epitrochlear node.

In the differential diagnosis of lymphadenopathy, one must consider tularemia, infectious mononucleosis, tuberculosis, Hodgkin's disease, lymphosarcoma, both benign and malignant tumors, and infected cysts.

We therefore believe the skin test for cat scratch disease should be employed early so that unnecessary diagnostic procedures, such as biopsy and bone marrow aspirations, may be avoided.

As to the therapy of cat scratch disease, it is apparently a self-limited disease with lymphadenopathy lasting two weeks to six months. There is no definite evidence that antibiotics are of any benefit.

Summary

Two cases of cat scratch disease in mother and child with different diagnostic and therapeutic approaches are presented.

It is suggested to all general practitioners and specialists that they give early consideration to cat scratch disease as an etiologic factor in cases of lymphadenopathy and that they use the intradermal test with the antigen for confirmation of the disease.

We wish to acknowledge with thanks the cooperation of Dr. Worth B. Daniels and Frank G. McMurray of Washington, D. C. for their antigen and cooperation.

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3920 Southwest Fifth Ter., Miami (Dr. Blinski).
220 Miracle Mile, Coral Gables (Dr. Kaye).

Clinical Observations on Use of Histamine In Medical Practice

CLARENCE BERNSTEIN, M.D.
AND
SOLOMON D. KLOTZ, M.D.
ORLANDO

The purpose of this paper is to report observations on the clinical use of histamine as we have employed it over the past 15 years. New interest in histamine has arisen from various sources. Certainly the pioneer work in its clinical evaluation should be credited to Horton,[8,9] whose early reports led Jonez[10-12] to use it intravenously in the treatment of multiple sclerosis and thereby to make his notable contribution in this hitherto arid field. At about the same time, unaware of Jonez' great work, we started to attack this clinical problem, albeit in a small way, and will report our results in this communication. Perhaps the initial work of Horton[8] prompted Prince and Etter[13,14] to employ histamine by vein for severe penicillin reactions of the status urticatus variety, which he reported to the American College of Allergists at the St. Louis meeting in 1949, and for certain types of serum sickness reactions. Butler[2,20] has continued to record the value of histamine in certain types of headache, and latterly the histamine-platelet relationship which he is currently pursuing.

A particularly lively spurt in interest in histamine stems from the synthesis and subsequent wide use of the so-called antihistamine drugs. This fact has called for a re-evaluation of many of our theories and basic concepts regarding the pharmacologic and physiologic actions of this intriguing and challenging substance, histamine. Its role in and relationship to allergy and anaphylaxis in animal and man have been doubted, confirmed, and fought over. Even its accurate quantitative estimation in blood and tissues has been questioned. Brilliant reviews of the subject have been prepared by Dragstedt,[4] Rocha e Silva,[21]

Read before the Decennial Congress of the American College of Allergists, Miami Beach, April 8, 1954.

Rose,[15] Selle[16] and others, and one cannot but conclude that while we have learned greatly, bit by bit, the full story of histamine has not been written. Not only has it not been written, but when it is, it will be different for man in some important respects as compared to animals, as well as between the various animal species.

As Horton[8] stated, "In order to understand the clinical use of histamine, it is necessary to appreciate its physiologic effects in man." Principally these are a contraction of smooth muscle, a dilatation and increased permeability of capillaries, and an increased secretion of various glands. Code[22] added a comment regarding histamine as the chemical mediator for pain, and Horton and his co-workers[8,9] recorded increased blood flows, especially to the central nervous system, heightened basal metabolism and oxygen consumption, and certain T wave changes in the electrocardiogram. These investigators postulated effects on the glands of internal secretion similar to those of ACTH and cortisone, but in general more rapid, more intense, and of shorter duration. Horton[8] recounted the remarks of Dr. Charles Best, who observed the work on histamine, and the words of Sir Alexander Fleming several years later: Dr. Best commented, "I would like to spend the rest of my life studying histamine," and Dr. Fleming said, "Histamine may prove more useful than penicillin."

Histamine in Gelatin

Our initial interest in histamine was in connection with the search for a nonspecific means of desensitization in allergic states. It seemed logical to use histamine, if, as was supposed, this substance mediated the allergic reaction. Whether the injection of histamine actually could desensitize or whether it simply increased the tolerance for histamine, and hence allergies, did not seem too important if the feat itself could be accomplished.

Accordingly, we began first to use increasing doses of histamine in various clinical conditions such as vasomotor rhinitis, perennial and seasonal hay fever, eczemas, and bronchial asthmas. We found that the effects were transitory and of little value.

We next searched for a "slow" histamine and learned that a histamine-azoprotein compound was soon to be available. We declined to use it as the protein used was "despeciated horse serum" which was coupled with an azo dye, and we feared reactions as well as potential sensitizations from its use.

At this time we asked Armour Laboratories to prepare the histamine analogue of their epinephrine-in-gelatin for us. This they did, making it in two strengths, 0.275 mg. of histamine acid phosphate per cubic centimeter and 2.75 mg. of histamine acid phosphate per cubic centimeter. We called this product "histagel" ("mild" and "strong" respectively), and began to make several types of evaluations. Lately we have made this product in our own laboratory as follows:

Formula:		
	Gelatin	160 Gm.
	Glycerine	160 cc.
	Chlorobutanol	5 Gm.
	Sodium Chloride	9 gr.
	Distilled water qs to	1000 cc.

Histamine diphosphate then is added, either 275 mg. or 2,750 mg. to prepare the "mild" or "strong" material, respectively. The gelatin formula supplied by Armour Laboratories is practically identical with that originally reported by Spain, Strauss and Fuchs[17] for use in epinephrine-gelatin mixtures. The histamine-gelatin mixture thus prepared remains stable for long periods of time, and the observable effects of a given dose appear to be uniformly within the range of biologic variation. In contrast to earlier oil mixtures and present day emulsions, histagel appears to be superior in this respect. Our experience suggests that this superiority is due in part at least to a reduced tendency for the histamine to "pool out" of the gel, or to layer, thus permitting relatively larger doses of the actual active histamine in the earlier withdrawals from the vial. More careful and thorough shaking of the vial helps to avoid this error.

In at least 5,000 cases of various types of allergies, predominantly in the respiratory group, we have used histagel in the following manner:

1. Alone as a nonspecific agent for desensitization
2. In conjunction with specific hyposensitization
 (1) When the desired clinical effect had not been achieved
 (2) When it was known that factors other than those used for desensitization were in all probability producing symptoms, but could not be demonstrated

Dosage. — The dosage was determined by the size of the local reaction, and when present, by

the extent of any general histamine response, such as flushing, headache and a pounding heart. We tried always to stay well below a generalized reaction, however insignificant. The starting dose of 0.10 cc. of the "mild" preparation was increased by 0.05 or 0.10 cc. once or twice weekly. As the dose neared the 1.0 cc. mark, the "strong" material then was used in about one-tenth the dose and with caution, since the diffusion rate allowed for more rapid effects in the higher histamine concentration. To a great extent this danger was already largely overcome by the now already increased tolerance for the histamine.

RESULTS. — Histagel alone has not been so effective as when specific hyposensitization has been possible and available. When added to a specific hyposensitization program, however, it has been most valuable, especially in vasomotor rhinitis and asthma. Over the years we have found that some patients who travel annually discover that histagel injections alone "hold" pretty well, if they have some along for self administration, until their "next pollen and dust doses catch up" with them en route. This may be "security-feeling via hypo" and might well be subject to critical analysis. We, however, have looked on this preparation as an "umbrella" with which to cover some of the myriad of unknown agents to which a patient may be sensitive. We have found repeatedly that the addition of this material to the treatment battery has rewarded both the patient and ourselves. Our controls in this regard have been previous experience without histagel in the same patient, and with previous additions to hyposensitization treatment of house dust extract or other nonspecific agent without discernible benefit.

On extremely rare occasions we have discontinued histagel because of local soreness, or because the patient felt less well with it, but we have had no notable untoward reactions. There have been no reported sensitizations to gelatin from its use, no peptic ulcers, or local lesions at the site of injections (or infections), and no asthmatic seizures from the injected material.

In some forms of dermatitis and urticaria we are using highly dilute histamine, plain, along with dilute allergen mixtures, but are not yet prepared to say whether this is a useful addition.

Intravenous Histamine

Our experience with intravenous histamine bears out the hopeful reports of Horton.[8] We have seen no real histamine cephalgia, and have been disappointed in the effects on nonspecific headache. Following intravenous therapy we have the patient continue on histagel or occasionally of late on Histapon (Endo), and believe that this enhances and prolongs any clinical result obtained.

MULTIPLE SCLEROSIS. — In multiple sclerosis we start intravenous treatment with 250 or 500 cc. of a 5 per cent solution of glucose in saline or distilled water, containing 2.75 mg. of histamine acid phosphate. This is started at 40 or 50 drops per minute and in every case is increased, if necessary, to produce and maintain a flush. Mild sedation is used in the early phase of this therapy, but generally may be quickly discontinued. Food or aluminum hydroxide gel is given every two hours while the drip runs, and for one hour thereafter. The usual headache tablets are prescribed as needed, but these, too, are seldom required.

Improvement in this group is remarkable, but cannot be laid to histamine alone. Vitamins, physiotherapy and psychotherapy are employed, and strict attention is paid to possible allergic offenders. Smoking is prohibited, and a constant air of optimism must be maintained. All of this has been brought out in Jonez' reports,[10-12] and we confirm his findings. Other investigators could not support Jonez' claims or the results of our own much smaller group, 11 in number. The over-all program, the effect of physicians and personnel and general surroundings, especially climate and temperature changes, may well be more important than the histamines in this notoriously remissive disease. The test of time and the reports of other workers using similar methods are now needed to formulate more specific measures for the treatment of these hitherto unrelieved patients.

Multiple sclerosis of long standing or in patients past 45 years of age does not respond to treatment as well as in the younger age groups. The earlier in its course this disease is treated, the better the outlook. Incidental allergies, of skin or respiratory tract, appear to be benefited at the same time, even though no specific allergy measures are taken. We have not generally needed to use Tubadil in our series. When muscle spasm is severe and a predominant feature, it is employed.

In addition, we have treated 2 patients with progressive spinal sclerosis, so-called, without benefit, and one patient with poliomyelitis of long standing, with similar failure.

VASOSPASM OR OCCLUSION. — We have seen

another group of patients with various clinical entities treated with intravenous histamine, which we mention briefly:

One patient with vasospasm, cold limbs, and a positive Babinski sign on the right side showed prompt reversal to normal, and had warm extremities thereafter.

A man, aged 64, had a right hemiplegia with aphasia, followed by depression and spells of crying. Eight days later, following three intravenous injections of routine histamine, he was smiling, making words and short sentences, and a few movements of the arm and leg.

A 74 year old retired government service man with advanced sclerotic changes had a cerebral thrombosis with right hemianopsia and general befuddlement. One week later he received two intravenous injections, followed 24 hours later by return of 75 per cent of the former vision, and improvement continued on histagel.

A housewife, aged 34, with lupus erythematosus went into an acutely agitated state with mild hypertension and severe vertigo. Intravenous injections on three successive days induced prompt return to adequate base line status.

An 80 year old housewife with left hemiplegia of one year's duration had a fair return of function except for stiffness and pain in the left side and a wobbly left ankle. Three intravenous injections gave a prompt sense of well-being, a firmer ankle, and freedom from need of a cane or support.

A retired attorney, aged 86, still active in his personal affairs, complained of general enfeeblement, confusion, fatigability, sleeplessness, and loss of memory for extremely recent events, all to a disturbing degree. He improved after the first intravenous injection and following two more injections he was delighted with his subjective improvement.

A 56 year old civic leader reported slight weakness of the right foot for the past year. Studies revealed no evidence of a brain tumor. There was slight hyperactive knee kick on the same side with a suggestive positive Babinski sign. He was seen in a University Clinic and urged to take a long course of therapy and diet. He preferred to try histamine. Great improvement was noted after the first two intravenous injections. He will continue on histagel and report for periodic repeat treatments.

These and other cases have shown gratifying response to this type of therapy. The results are undoubtedly due to the known physiologic effects of histamine plus one additional factor. This is the high venous oxygen tension resulting from the histamine. Relapse has not been frequent, a feature which has been surprising. Horton's experience, however, with this type of material has been roughly similar, and we concur in his high estimate of the wide usefulness of intravenous histamine.

There have been no untoward effects — no asthma, ulcers, angina, or coronary thrombosis.

Penicillin Reactions (Status Urticatus). — We have employed intravenous histamine as outlined here and by Prince and Etter[13,14] for the treatment of this increasingly troublesome and at times distressing and dangerous complication. Prior to ACTH and cortisone this was all we had that was effective. The antihistamines, Adrenalin, and ephedrines were most often useless in the severe types. We have seen a few cases in which even corticoid therapy was not helping, though timid dosage might have been a factor.

Even so, it is our experience that intravenous histamine offers quicker comfort to the patient and a prompter subsidence of the lesion than do the corticoids. One patient with large blue-black, elevated disklike swellings of varying sizes began to gain relief only as the histamine flowed into the vein. This may need repeating the same day or the next, and at times the dose of histamine may triple or quadruple the usual amount.

We have found no therapeutic paradox in using intravenous histamine and ACTH; indeed in several instances of severe unremitting urticaria, one or two nonspecific, we thought that the combination brought about or materially hastened recovery. The use of the two together, ACTH and histamine, can be strongly recommended when the usual methods have failed of the desired result.

Comment

Our observations would tend to confirm those of Horton,[8,9] Prince,[13,14] Jonez[10-12] and others that histamine has considerable, and perhaps as yet unexplored, value as a therapeutic agent. It should not be used without great care, but thus far seems to have been free of any untoward effects. As Horton[8] said, "In order to rationalize the therapeutic use of histamine in such a wide variety of clinical entities, it is necessary to appreciate fully the known pharmacologic and physiologic effects of this agent in human beings. No

other drug has such a wide variety of actions as those possessed by histamine. There is hardly a tissue organ in the human body which will not respond in some way to this powerful agent. The response to histamine is often dramatic. Its participation in normal and disturbed physiologic processes is of far greater significance than many physicians realize.

"Histamine, however, is not a cure-all in any sense of the word, but is a useful drug if employed wisely. Many of the clinical results can best be explained by the action of histamine on the cortex of the suprarenal gland. . . . histamine causes the release of cortisone. . . . When the complete story of histamine finally has been written, it will constitute one of the most romantic chapters in the history of medicine."

Summary

The known pharmacologic and physiologic actions of histamine endow it with various therapeutic properties of considerable range. These have been utilized in the treatment of several clinicopathologic states, such as vasospastic or occlusive phenomena, neurologic and allergic disorders.

We have employed histamine in gelatin as an adjunct to specific therapy in hyposensitization in allergic states. In conjunction with specific hyposensitization it is a worth while therapeutic addition, whereas when used alone nonspecifically it appears to have little value.

Intravenous histamine in the treatment of multiple sclerosis along with other supportive therapy, and with allergic management, offers real help to the distressing group of patients with this disease. The possibility that the program itself constitutes psychotherapy in full panoply must be born in mind in evaluating results.

In status urticatus and severe penicillin reactions, intravenous histamine has been most effective, and perhaps more rapidly so than ACTH or cortisone.

The need for caution and careful attention to details in this treatment program is emphasized. At the same time the ease of accomplishment and freedom from complications when it is properly utilized strongly recommend its use.

Further observations on the clinical effects of histamine are urged as its great value in the therapy of a wide variety of conditions is only just beginning to be realized.

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Diagnosis and Treatment of Intracranial Aneurysms

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At the outset, I should like to quote the late Dr. Walter E. Dandy:[1] "Intracranial Arterial Aneurysms, always considered rare and almost impossible both of diagnosis and treatment, are now added to the lengthening line of lesions that are curable by surgery. This is another example of the results that can be attained from intensive cultivation of a seemingly barren field. Accumulating pathological studies first called attention to the lesion. Many years passed without apparent diagnostic or therapeutic possibilities; gradually an increasing number of cases in the hands of neurologists suggested potential diagnostic criteria, and actual diagnoses were, after a time, occasionally made and confirmed at necropsy. In the course of time, when neurosurgery became concentrated in the hands of a few, lesions were now and then found at operation, at first only to be regarded as curiosities, but eventually with such increasing frequency that the problem demanded solution. Largely through trial and error, methods of attack have unfolded. With increasing confidence in diagnosis, and with the correlated surgical follow through, they are now known to be quite common, and many at least to be amenable to cure with a surprisingly low mortality."

The foregoing statements adequately sum up the situation pertaining to intracranial aneurysms. Although aneurysms of the brain were first recognized at necropsy by Morgagni in 1761, it was not until 1875 that aneurysms were diagnosed during life and confirmed at necropsy. During the past 20 years much interest has been centered around these lesions, and within the past 10 years a tremendous number of communications have appeared concerning intracranial aneurysms. Poppen,[2] in 1948, stated that in a series of 110 aneurysms only 9 intracranial aneurysms were encountered in a 10 year period, whereas 101 were found in the past four years, mainly because of an awareness that such a condition might be present.

Ruptured intracranial aneurysms constitute the main type of intracranial hemorrhage, or intracranial vascular disease. The term "stroke" loosely applies to one of several forms of cerebral vascular accidents such as cerebral vascular spasm, spontaneous hemorrhage into the internal capsule, cerebral thrombosis, and cerebral embolism. It is not generally recognized that ruptured intracranial aneurysms are exceedingly common lesions, that certain of these lesions produce definite clinical signs and symptoms by which they can be recognized clinically, and that many are amenable to surgical cure. Hamby[3] reported that in 130 cases of spontaneous subarachnoid hemorrhage, the bleeding originated in ruptured intracranial aneurysms in 93.6 per cent. Martland[4] observed that practically all cases of fatal subarachnoid hemorrhage are due to ruptured intracranial aneurysms. Since many of these lesions can be cured and since the mortality rate can reasonably be expected to be lowered even more with better and improved methods of diagnosis and treatment, it behooves physicians to examine more closely the mechanism of production of subarachnoid hemorrhage in order to attain a high degree of accuracy in diagnosis of these lesions.

The brain is supplied with blood by two great arterial systems, the carotid and the vertebral. After entering the skull the internal carotid artery comes to lie within the cavernous sinus in close apposition to the fifth cranial nerve and to the third, fourth and sixth nerves. After first passing anteriorly, the artery then curves backwards and divides into the middle and anterior cerebral arteries, which together with the anterior communicating artery form the anterior portion of the circle of Willis. The posterior part of this circle is derived from the vertebral system, the vertebral artery of either side joining to form the basilar artery, which in turn gives off vessels to the pons and cerebellum, and divides into the posterior cerebral arteries. The circle is completed by the posterior communicating arteries which join the posterior cerebral vessels to the anterior portion of the circle of Willis. Aneurysms may occur at any point on any of these vessels, and certain signs to be described later may indicate the exact location. In a later paper, Poppen[5] stated that 75 per cent of aneurysms occur in the anterior two thirds of the circle of Willis, and this is a fortu-

nate site since these areas are the more accessible surgically.

Aneurysms may be of congenital, mycotic, or arteriosclerotic origin. The cause is thought to be a defect in the medial coat of the vessel, which eventually causes the wall to become progressively weaker and finally to rupture. The resulting hemorrhage may be a relatively minor one and confined to the subarachnoid spaces, or it may actually plow into the brain substance with production of massive destruction of nervous tissue, and increased intracranial pressure. This disruption of the brain may be so extensive as to involve the ventricles. While in most cases a ruptured aneurysm produces subarachnoid hemorrhage, it is possible for it to occur without bleeding into the subarachnoid spaces, as reported by Hyland.[6] In his case there was a rupture of a larger aneurysm into the deep temporal lobe without producing subarachnoid hemorrhage.

Symptoms

The symptoms of ruptured intracranial aneurysm are those which would be expected with a sudden hemorrhage of the brain with bleeding into the subarachnoid spaces. The patient will almost invariably complain of sudden onset of violent headache. This is usually accompanied by nausea and vomiting, and there may be all stages of disturbance of consciousness ranging from extreme coma to a slightly dazed or confused state. All too frequently sudden coma is the first evidence of the existence of an aneurysm. Patients complain of sudden repeated sharp pains in the eye, or in the frontal or temporal region, frequently followed by ptosis of the eyelid and extraocular palsies of the same side. These manifestations are almost pathognomonic of carotid or nearby aneurysms.

Although hemiplegia can occur with any aneurysm located above the tentorium, it is far more common with aneurysms of the middle cerebral artery. The cause of the hemiplegia is extension of hemorrhage into the sylvian fissure or over the cortex of the brain. Bassett and Lemmen[7] reported 5 cases of subdural hematoma associated with ruptured aneurysm, and this complication occurred in 2 of my cases. At times a monoplegia occurs with lesions of the anterior cerebral artery. Bilateral motor loss may indicate that the aneurysm originates from the vertebral or basilar arteries. A positive Babinski sign is one of the most frequent signs of intracranial aneurysm. The sign may be unilateral or bilateral, but has no localizing value. It is frequently present even though motor loss is not apparent. Stiffness of the neck is almost always present with subarachnoid hemorrhage and is due to irritation of the meninges of the posterior cranial fossa. If the aneurysm ruptures into the subarachnoid or ventricular spaces, I believe it can be safely said that the neck will be stiff. Although not as common as nuchal rigidity, there is often low back pain with stiffness of the back and even, in some cases, severe sciatica due to irritation of the lumbar meninges and components of the sciatic nerve by blood. Dandy[1] stated that when the neck is rigid after a sudden episode referable to the brain, it is almost as certain evidence of subarachnoid hemorrhage as the findings by lumbar puncture.

A positive Kernig sign is commonly present during and for several days after hemorrhage. It is nearly always bilateral and is due to the collection of blood in the posterior cranial fossa and spinal subarachnoid spaces. Convulsions are sometimes noted and, when present, they denote cerebral damage which may be due to previous rupture of the aneurysm or to its actual size and position in the brain.

Subhyaloid retinal hemorrhages are frequently noted and are thought by some to be pathognomonic of ruptured aneurysm. Papilledema, sometimes present, is due to increased intracranial pressure. Aneurysms can occur in any age group. They occur in only a few patients under the age of 10 years and a few under 20 years. Thereafter, the aneurysms are fairly uniformly distributed in frequency in succeeding decades until the age of 70, when they decline.

Roentgen Diagnosis

In addition to a careful history and physical examination, roentgenograms of the skull should be made in all cases of intracranial hemorrhage. In most cases these studies will be completely normal, but in many calcification in the wall of the aneurysm can be detected. This may be in the form of small circular or crescent-shaped shadows, irregular masses, diffuse scattered areas about the sella or in the carotid canal, or linear curved shadows. Sometimes there may be erosion of the sella turcica by the aneurysm.

The most valuable aid in demonstrating the presence of aneurysms is cerebral angiography. This procedure, first introduced by Egas Moniz in 1927, consists in the injection of a contrast medium into the carotid or vertebral vessels. This substance is rapidly carried by the blood stream

into the cranial cavity, and by means of well timed exposures the intracranial vascular system, arterial as well as venous, is beautifully demonstrated. While this is a relatively easy procedure, technically speaking, it is by no means an innocuous procedure. In most cases there are no ill effects whatsoever, but convulsions, hemiplegia, and even death can occur. The most frequently used compounds are Diodrast and Thorotrast. Diodrast definitely has been shown to cause arterial spasm, and Thorotrast is stored within the reticuloendothelial system and has cancerogenic properties. Injection may be made by the percutaneous method, which is directly through the skin, or if the carotid artery is not easily palpable, the vessel may be exposed by a short incision in the neck under local anesthesia.

Treatment

The main object of any treatment of these lesions is to prevent further ruptures and thereby lessen the chances of fatality. Some authorities believe that arteriograms can be made with impunity soon after the rupture, while others state that it is dangerous to obtain them early because of fear of further vascular spasm. At any rate, when arteriography demonstrates the presence of an aneurysm, there are several procedures which might be followed: (1) simple ligation of the carotid artery; (2) ligation of the carotid artery in the neck combined with intracranial ligation, thereby trapping the aneurysm between the two ligatures; and (3) ligating the neck of the aneurysm intracranially. Ligation of the vessel in the neck is the simplest method and carries the lowest mortality, but according to Bassett, List and Lemmen,[8] hemiplegia or hemiparesis follows cervical ligation in 41.4 per cent of the cases. On the other hand, in their series of cases of intracranial ligation there was a 40 per cent mortality, but if the patient survives the operation, these authors think that success is virtually assured with little danger of recurrent bleeding. On the other hand, no one knows the ultimate outcome with the cervical ligation. Norlén and Olivecrona[9] of Sweden recently reported 63 cases and concluded that direct ligation of the neck of the sac, when feasible, is the method of choice.

Without going into a detailed discussion of the merits of each of these methods, I should like simply to point out that the treatment of each aneurysm is highly individualized, each case requiring considerable thought as to which method of attack is best suited to the particular aneurysm. Among the problems confronting the surgeon in making his decision, there is first of all the location of the aneurysm. He must know the tolerance of each cerebral hemisphere to reduced blood supply; he must know the risk involved in nonsurgical versus surgical intervention and the likelihood of a second hemorrhage; and he must know whether or not the aneurysm is located where its removal may cause permanent hemiplegia.[2]

To emphasize a few of the points mentioned, 2 cases of typical ruptured intracranial aneurysm are presented.

Report of Cases

Case 1. — R. M., a 46 year old white woman, was admitted to St. Vincent's Hospital on June 4, 1952. While at work two days previously, she had suffered a sudden severe generalized headache. She was seen in the emergency room by a local physician, and roentgenograms of the skull were made. The headache continued, and there was no relief with large doses of codeine. She experienced slight nausea. The past history was irrelevant except for a similar episode of severe headache when she was about 20 years old, which lasted only a short time. The family history was noncontributory, except that the mother was extremely nervous and the father was in a state mental hospital, having previously had a prefrontal lobotomy. His condition had caused the patient great anxiety.

On examination, the patient was somewhat asthenic, and was extremely nervous and apprehensive. She had intermittent jerking movements of the legs, which appeared to be voluntary rather than convulsive movements. The neck was extended slightly backwards and was moderately stiff. She complained of pain on flexing the neck. There was suggestive ankle clonus bilaterally. Laboratory tests including hematologic studies and urinalysis gave negative results. A spinal puncture had been performed by her local physician. The pressure was 150 mm. of water, and the fluid was grossly bloody. The tap was repeated the next morning and was essentially the same.

It was thought that the patient probably had an intracranial aneurysm, and on June 7 percutaneous arteriography revealed a small aneurysm of the right carotid artery just below the bifurcation. Arteriograms on the left side gave negative evidence. On June 11 the common, internal and external carotid arteries were exposed in the neck and the internal carotid artery was clamped temporarily for a period of 45 minutes without ill effects. She tolerated this procedure well, and the internal carotid artery therefore was ligated permanently. On June 16 a frontal craniotomy on the right side was performed, and a small aneurysm was found just beneath the anterior clinoid process. The medial surface of the right temporal lobe was stained bluish yellow as if there had been recent bleeding in this vicinity. A silver clip was placed on the carotid artery distal to the aneurysm, which was thereby trapped between this clip and the ligature in the neck.

The postoperative course was uneventful, and the patient was discharged on June 21. At that time there was some slight facial weakness on the left side and incontinence of urine. These symptoms cleared up completely, and when last seen on Oct. 2, 1953, she was doing well with no residual neurologic defects. She had been under the treatment of a psychiatrist for extreme nervousness, however, but her mother stated that this nervousness was no more than was usual for her.

Case 2. — J. W., a 54 year old white man, was admitted to the hospital on April 2, 1952. Six days previously he had experienced the sudden onset of severe headache during a period of physical exertion. At the onset the headache was described as being at "the base of the brain;" then later it became generalized. He complained of pain back of the eyes. He had been having considerable nausea

and vomiting. He also complained of pain in the back of the neck, which began one day after the onset of the headache, and progressed down the back to the low back region and radiated down the back of both thighs.

On examination, the positive findings were a moderately stiff neck, suggestive slight left central facial weakness, slight hyperreflexia on the left side, bilateral equivocal Babinski sign, and bilateral unsustained ankle clonus. Roentgenograms of the skull and chest gave negative evidence, as did laboratory tests. A spinal puncture was performed on April 7, the pressure being 200 mm. of water. The fluid was grossly bloody. On April 13, the patient again experienced severe pain of sudden onset in the low back and sometime thereafter he had simultaneous sudden pain in the back and head with rapid onset of unconsciousness, which lasted for about 10 minutes. At this time the reflexes seemed to be a little more hyperactive on the right. It was thought that there was a recurrence of bleeding.

On April 16, bilateral arteriography was carried out by exposing both carotid vessels in the neck, and a small aneurysm of the left internal carotid artery was demonstrated. The common carotid artery was temporarily ligated for 30 minutes with no immediate ill effects. Permanent ligature was then placed on the artery. Approximately five hours after ligation, there occurred sudden onset of aphasia and hemiplegia on the right side. The patient was taken to the operating room immediately, where the ligature was removed. There was no visible pulsation of the external carotid, or carotid vessels above the ligature. Apparently the vessel had thrombosed, and it is believed that a propagated thrombus had extended up into the intracranial vessels, thereby causing hemiplegia and aphasia. The hemiplegia has gradually improved, and he is now able to get about without the aid of crutches. Also, he is able to resume his regular office work, though he still has hemiparesis and aphasia of considerable degree.

Summary

Ruptured intracranial aneurysms are one of the most frequent causes of spontaneous subarachnoid hemorrhage.

Although rupture of these lesions causes death in a high percentage of cases, an awareness of the possibility that such a lesion might exist should lead to more accurate diagnosis, since many are amenable to surgical cure.

By means of arteriography, the intracranial vascular system can be visualized and aneurysms detected.

The object of treatment of these lesions is to prevent further hemorrhage, and this can be accomplished by one of three methods: (1) ligation of the carotid artery in the neck; (2) combined ligation of the cervical portion of the carotid artery and intracranial ligation; and (3) ligation of the neck of the aneurysm.

Treatment of ruptured aneurysm is individualized and depends on the age of the patient and the location of the aneurysm.

Two illustrative cases are presented.

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Lymphosarcoma of the Tonsil

Report of a Case

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Lymphosarcomas of the tonsil are still so rare that much difference of opinion exists regarding the optimal method of treatment. The consensus seems to favor tonsillectomy followed by radiation,[1,2] although one author[3] advised against surgery, and Berven[4] and Whitcomb,[5] among others, recommended radiation alone. Parshall and Stenstrom[6] recommended radon implantation following radiation, believing that the rate of survival is improved thereby.

All agree that differential diagnosis prior to surgery is difficult, and is frequently rendered more difficult by superimposition of infection and ulceration. Biopsy frequently yields negative results, even in the presence of obvious lymph node involvement,[5] and multiple biopsies are recommended. The clinical appearance does not permit differential diagnosis, and even the microscopic differentiation may be difficult. The reader is referred to the excellent paper by Whit-

comb[5] for discussion of the clinical aspects of tonsillar malignant disease.

In the case here presented a tonsillectomy was performed for diagnosis and therapy, it being our opinion that nothing would be gained by biopsy.

Report of Case

A 42 year old white man consulted his family physician (C.F.B.) on Oct. 28, 1954. He reported that he had had tonsillitis the previous week and complained of a persistent lump in the right side of the throat.

On examination, the right tonsil was about two and a half times as large as the left and was pressing the anterior pillar forward prominently. There was moderate erythema of the peritonsillar mucous membrane on both sides, and the pharynx appeared slightly inflamed. The tonsils did not appear inflamed, and no difference in their color was noted. No nodes were palpable in the neck. The temperature was normal. It was thought that the condition represented a subsiding infectious process, and hot saline gargles and Aureomycin troches were prescribed.

The patient returned a week later stating that he still felt fulness in the throat and that he had been startled that morning by noting a small amount of blood when he cleared his throat and expectorated. Re-examination revealed essentially the same findings, but it was noted that the right tonsil was pale and bled easily upon pressure with a cotton applicator. Malignant disease was then suspected, and the patient was referred to an otolaryngologist (T.M.E.) the same morning. He was hospitalized that afternoon.

On complete physical examination the only other significant physical finding was a firm node about 1½ cm. in diameter beneath the margin of the right pectoralis in the axilla. This node was freely movable, was not tender, and was round in contour. No other nodes were palpable. Roentgen examination of the chest gave no evidence of metastases. Routine blood work gave normal results.

On November 6 a tonsillectomy was performed by the dissection-snare method. The tonsils dissected out easily, and no difficulty was encountered in performing the operation. The patient was discharged routinely the following morning. The pathologic diagnosis was a malignant lymphoma of the tonsil of the reticulum cell sarcoma type. Immediate radiation therapy was advised, but the patient elected to go to a distant medical center for treatment. Beginning on November 19 he was given 5,100 r through two ports directed to the tonsils. Treatment was completed on Decemeber 18. He bore the radiation well and had minimal skin reaction.

When the patient was seen again on January 7, the right tonsillar fossa was moderately shrunken and appeared clean. The left tonsillar fossa was normally healed. No nodes were palpable in the neck; the enlarged node beneath the right pectoral margin had shrunk to about 5 mm. and was barely palpable. The patient appeared in good health and has since returned to work. We believe that the prognosis is fairly good.

Discussion

The absence of lymph node involvement, of infection and ulceration and of evidence of direct invasion were the deciding factors in the treatment chosen in this case. Tonsillectomy probably invites no greater clinical danger of metastasis than a single biopsy, and it would seem that multiple biopsies definitely increase the risk. In uncomplicated tonsillar tumors, therefore, it would appear that tonsillectomy is the best diagnostic procedure, and that biopsy should be reserved for cases in which infection and ulceration render tonsillectomy impossible.

We have no explanation for the presence or regression of the pectoral node. We had intended to remove this node prior to radiation, but the physicians at the clinic to which the patient went noted its presence and apparently elected not to do so. Their judgment seems to have been borne out by its subsequent disappearance. We will try to follow this patient and make a later report on his progress.

Summary

A case of lymphosarcoma of the tonsil is reported in which a tonsillectomy was performed for diagnostic and therapeutic purposes and was followed by radiation therapy.

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Information which will be useful in completing 1955 income tax forms may be found in the booklet "Federal Income Tax Liability of Physicians." A copy of the booklet is available on request from the Law Department of the American Medical Association, 535 N. Dearborn St., Chicago 10, Ill.

ABSTRACTS

Cesarean Sections at Grady Memorial Hospital (1948 to 1953). By C. J. Arnold, M.D., and John R. McCain, M.D. South. M. J. 48:710-717 (July) 1955.

The authors present the indications for and the results of cesarean section in a large series of cases at Grady Memorial Hospital in Atlanta, Ga., where the incidence of sections has remained low despite a significant rise in recent years in many hospitals. At this general hospital handling only service cases the experience is used to demonstrate the advantages and disadvantages of a low incidence of cesarean section under present day conditions.

An analysis of the 197 cesarean sections performed among 27,772 deliveries disclosed that the infant loss of the patients delivered by section was 10.9 per cent, or two and one half times the 4.35 per cent incidence of stillbirth and neonatal deaths for all deliveries at the hospital. The most frequent indication for section was a previous cesarean operation, occurring in 43.1 per cent of the cases. Previous sections, combined with hemorrhagic conditions, and pelvic contraction and mechanical dystocia, accounted for 91 per cent of the indications for section. Conditions other than the cesarean operation itself were responsible for the deaths of 13 of the 22 infants who did not survive. Operative procedures and technics caused no infant deaths, but were associated with the three maternal deaths.

It was concluded that improvement in results would follow more frequent section for pelvic contraction and mechanical dystocia, combined with a shortened period of labor; that a higher percentage of patients with a partial placenta previa should be delivered by cesarean section; and that more frequent section on diabetic patients and patients with malpresentations would give better infant results. It was considered safest to continue the policy of performing "repeat" sections upon women who had had previous sections. The vaginal route was regarded as safest for the delivery of patients with toxemia and with abruptio placenta. The decision regarding the method for delivery also is influenced by the risks to the mother. In this study the maternal mortality rate was 9.0 per 10,000 deliveries, but for deliveries by cesarean section it was 1.5 per cent.

The authors deemed it unwise to advise any specific incidence of cesarean section as the "proper" figure for the sections by a good obstetrician or by a good obstetric department. In their opinion the proper incidence of cesarean sections will be the result of a careful selection of the patients for the operation.

Intrapleural Enzymatic Debridement with Tryptar. By Hawley H. Seiler, M.D., F. C. C. P. Dis. of Chest 27:179-189 (Feb.) 1955.

The author describes 8 cases which illustrate some of the situations in which the pancreatic enzyme trypsin can be used for the purpose of selective intrapleural proteolytic debridement. Included are tuberculous empyema, tuberculous infection of the extrapleural space, mixed tuberculous empyema, nontuberculous empyema following resection for tuberculosis, nontuberculous postoperative empyema, and nonspecific bilateral pleural effusion of an indeterminate nature.

In 2 cases of tuberculous empyema and 2 cases of postoperative empyema cure was complete, and in 1 case of bilateral effusion of unknown origin almost complete relief was obtained. In the remaining 3 cases improvement was manifested by decrease in viscosity and sterilization of the fluid, which contributed to eventual good surgical results. These initial encouraging experiences led to tryptic debridement in 22 additional cases with comparable results. This method also was employed successfully in the treatment of postoperative and traumatic hemothorax. The trypsin used was tryptar, a pure crystalline trypsin.

It is concluded that tryptic debridement is a valuable adjunct in the treatment of intrapleural infections and hemothorax and deserves to be more widely employed. Side effects are few and inconsequential. Its use is not necessarily contraindicated in the presence of bronchopleural fistula.

Reaction to Antibiotics. With Special Reference to Penicillin. By Joseph Farrington, M.D. South. M. J. 48:657-662 (June) 1955.

After discussing untoward reactions from antibiotics in general, listing some of the known mechanisms by which these and other drugs produce reactions other than by allergic sensitization, and presenting a classification of some of the deleterious effects from antibiotics, this author considers in some detail their prototype, penicillin. Still most widely used, penicillin continues to head not only the list of antibiotics but of all medicinal agents in frequency, diversity and severity of the reactions which it induces. Currently, it has supplanted foreign serums as the commonest cause of fatal anaphylactic shock.

In view of the ever mounting importance of the problem of penicillin sensitivity and the multiplicity of forms in which penicillin reactions may occur, Dr. Farrington discusses the production of penicillin and efforts to locate the source of the substances producing the reactions. In table form he presents a workable clinical classification of untoward reactions to penicillin and discusses in particular urticaria, the commonest one, and also contact dermatitis resulting from the local use of penicillin. In addition, he discusses superinfection. Under prophylaxis he mentions simple rules by which reactions can be avoided. In conclusion, he offers five therapeutic measures for the management of these reactions.

As more of the population become sensitized to penicillin, an increasing number of severe reactions may be anticipated. The physician who reads this latest of a number of articles by Dr. Farrington on this subject thereafter will be inclined to ask himself as he prepares to inject this antibiotic, "Is it indicated?"

Synchronous Combined Abdominal-Right Thoracic Approach for Carcinoma of the Middle and Upper Thoracic Esophagus. By Hawley H. Seiler, M.D. J. Thoracic Surg. 28:305-309 (Sept.) 1954.

Experience has demonstrated, this author observes, that in many instances carcinoma of the thoracic esophagus, especially in the middle and upper portions, is not curable by surgical means because of the extensive nature of the lesion and involvement of adjacent structures. A considerable degree of relief and restoration of swallowing, however, may be afforded patients with this lesion by esophagectomy and esophagogastrostomy. Even in nonresectable lesions, symptomatic relief can be afforded by by-passing the carcinoma with a proximal esophagogastrostomy. Such a program is readily accomplished by means of a synchronous combined abdominal-right thoracic approach. With two surgical teams operating simultaneously, one in the abdomen and one in the right thorax, the operative time is shortened considerably. By positioning the patient on the table at a 45 degree angle, it is possible for both teams to work comfortably, and there is no need for repositioning of the patient at any time. The operation is thus actually a one stage, two team procedure rather than a two stage operation. The procedure is technically less difficult through the right chest, and anastomosis is somewhat facilitated for a right-handed surgeon.

In applying synchronous combined abdominal-right thoracic approach to lesions of the middle and upper thoracic esophagus, one must maintain the underlying philosophy that resection can be done in all cases, although admittedly palliative in many instances. Dr. Seiler's modification consists of starting simultaneously and performing synchronously the abdominal and thoracic phases of the operation, somewhat after the fashion of the British surgeons in performing synchronous combined abdominoperineal resection of the rectum. Esophageal carcinoma is thus approached with the attitude that the lesion will be resectable and, if not, that a palliative by-pass procedure will be performed to restore deglutition.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 1018, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

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A Prayer for Physicians

Guest Editorial

Frank G. Slaughter, M.D.

With the coming of the Christmas Season, people everywhere stop, for a few moments at least, to give thanks for the coming of One whose love for His fellows was so great that He gave up His life in order that they might find a way to God through His example. The history of medicine contains the names of many martyrs who sacrificed their own lives to further the science of saving others through advances in the healing art. These were truly following the teachings of Jesus, when He said: "Greater love has no man than this, that a man lay down his life for his friends."

In the complex and highly organized structure of medical practice today, few men are called upon to lay down their lives for their fellow men. Yet medicine still demands of its servants the same idealistic devotion to service for others that has characterized it down through the centuries. And with the complexities of scientific practice always tending to compress a physician's activities into smaller and smaller phases of medicine as a whole, perhaps we need still to pause at Christmas time, if at no other, and say a prayer that we be strengthened in pursuing the idealistic side of our calling, while increasing our knowledge of the scientific.

Never, certainly, was the prayer of the true physician more beautifully or truly expressed than by the Jewish physician Maimonides in the twelfth century, when he wrote this Oath and Prayer:

> "Thy Eternal Providence has appointed me to watch over the life and health of Thy creatures. May the love of my art actuate me at all times; may neither avarice, nor miserliness, not the thirst for glory, nor for a great reputation engage my mind; for the enemies of Truth and Philanthropy could easily deceive me and make me forgetful of my lofty aim of doing good to Thy children.
>
> "May I never see in the patient anything but a fellow creature in pain.
>
> "Grant me strength, time, and opportunity always to correct what I have acquired, always to extend its domain; for knowledge

is immense and the spirit of man can extend infinitely to enrich itself daily with new requirements. Today he can discover his errors of yesterday and tomorrow he may obtain a new light on what he thinks himself sure of today.

"O God, Thou has appointed me to watch over the life and death of Thy creatures; here I am ready for my vocation.

"And now I turn unto my calling:

O stand by me my God in this truly important task;

Grant me success! For—

Without Thy loving counsel and support,

Man can avail but naught.

Inspire me with true love for this my art

And for Thy creatures,

O, grant—

That neither greed for gain, nor thirst for fame, nor vain ambition,

May interfere with my activity.

For these I know are enemies of Truth and Love of men,

And might beguile one in profession

From furthering the welfare of Thy creatures.

O strengthen me.

Grant energy unto both body and the soul

That I might e'er unhindered ready be

To mitigate the woes,

Sustain and help

The rich and poor, the good and bad, enemy and friend.

O let me e'er behold in the afflicted and suffering,

Only the human being."

Moses ben Maimun, author of this lovely and inspiring prayer, practiced the precepts he taught. Although forced to flee from his native city of Cordova, where he was a pupil of the great Averroës, his skill in medicine earned him at twenty-five the position of private physician to Saladin, the Scourge of the Crusaders. Tradition states that at Acre, Saladin sent Maimonides to treat his wounded enemy, Richard the Lion-Hearted of England, and that Richard offered him the position of personal physician, if he would return home with the English king. Maimonides, however, loyally refused this high position, adhering to the lofty precepts cited in his Oath and Prayer.

A Jewish physician, residing in a Mohammedan land, gave the medical profession a most beautiful restatement of the precepts taught by Jesus. We can do no better at Christmastime than to dedicate ourselves anew to the standards set for our art by Moses ben Maimun.

Editor's Note: The Journal is honored to have for the third consecutive year a guest editorial befitting the Christmas Season from the pen of Dr. Frank G. Slaughter, of Jacksonville, Florida's distinguished physician-author.

American College of Surgeons Sectional Meeting

Jacksonville, Jan. 16-18, 1956

The American College of Surgeons announces that its first Sectional Meeting of the 1956 season will be held in Jacksonville on January 16, 17 and 18. Surgeons and members of the medical profession at large are invited to attend. Dr. Kenneth A. Morris, of Jacksonville, is chairman of the Local Advisory Committee on Arrangements. The sessions will be held at the George Washington Hotel.

An exceptionally practical program has been planned. It will include discussions of management of mass casualties, the ulcer problem, spinal cord injuries, biliary tract surgery, esophageal reconstruction with colon transplant, pancreatitis, ureteral injuries, arterial occlusions, fluid and electrolyte problems, lesions of the esophagus, intestinal obstruction, cine clinic films from the 1955 Clinical Congress, and three symposiums, on cancer, gynecology, and a motion picture group.

On Monday morning, January 16, Dr. Morris will preside over the opening session, which will be devoted to "Management of Mass Casualties." Dr. Joseph S. Stewart, President of the Florida Chapter of the American College of Surgeons, will preside over the afternoon session. The program will cover some of the major problems in surgery today and will include a "Panel on Biliary Tract Surgery."

At the dinner meeting on Monday evening, with Dr. I. S. Ravdin, of Philadelphia, presiding, Dr. Paul R. Hawley, Director of the American College of Surgeons, will be among the speakers. A new motion picture, entitled "Danger at the Source," will be shown. It should be of great interest to all medical and educational groups concerned with the problem of more support for the nation's medical schools. Sponsored by the National Fund for Medical Education, this picture has been prepared for the express purpose of mobilizing private financial support for these

schools through fostering training of a sufficient number of competent physicians to meet the nation's health needs, interpreting the needs of medical education to the American public, encouraging advancement of medical training standards in the United States, and preserving academic freedom and equality of educational opportunity.

The program on Tuesday, January 17, is widely diversified. Dr. Walter C. Jones, of Miami, will preside over the morning session, and in the afternoon Dr. J. K. Quattlebaum, President of the Georgia Chapter of the American College of Surgeons, will preside. A "Symposium on Cancer" and a "Panel on Varicose Veins and Leg Ulcers" are features of the afternoon program. At night, Dr. Norborne R. Clarke, President of the Alabama Chapter of the American College of Surgeons, will preside over a "Motion Picture Symposium of Cine Clinic Films."

On Wednesday, January 18, Dr. Edward Jelks, of Jacksonville, will preside over the morning program, which includes a "Panel on Intestinal Obstruction" and a "Symposium on Gynecology." In the afternoon, a "Motion Picture Symposium" will conclude the program. Motion pictures will also be shown preceding both sessions on Monday and the morning session on Wednesday.

Serving with Dr. Morris on the Local Advisory Committee on Arrangements are the following Jacksonville physicians: Drs. Donald M. Baldwin, Frederick H. Bowen, John R. Browning, Samuel M. Day, Edward Jelks, Karl B. Hanson, F. Gordon King, Raymond H. King, Wilbur C. Sumner, Frederick J. Waas, and Ashbel C. Williams.

The Ladies Entertainment Committee is headed by Mrs. Wilbur C. Sumner, Chairman. Serving with her are Mrs. G. Dekle Taylor, Mrs. Samuel M. Day, Mrs. Raymond H. King, and Mrs. William A. Van Nortwick.

National Compulsory Disability Benefits

The importance of physicians keeping informed about the dangers inherent in the program of compulsory disability insurance for some 55 million persons now under social security, which is pending in the Congress, was stressed editorially in the November Journal. A Democratic-sponsored bill amending the Social Security Act to provide for a program of compulsory disability insurance for persons 50 years of age or older passed the House last July and was sent to the Senate Finance Committee. Extensive hearings are forecast early in the forthcoming second session of the 84th Congress.

The American Medical Association is strongly opposed to this proposal, for it is believed that it would project the federal government into the practice of medicine because of the necessity for medical determination of disability. Also foreseen are a decline in the number of persons seeking rehabilitation and an excessive drain on the social security trust fund when disability payments are made. In late October, some 100 representatives of constituent state medical associations, A.M.A. officers and members of its Board of Trustees met in Chicago to discuss methods of informing its membership of certain aspects of pending legislation and to consider approaches for focusing the public's attention upon the A.M.A.'s viewpoint. Opinions expressed by participants in the meeting are currently being studied by A.M.A. officials, and their further comments, suggestions, or criticisms were invited. Dr. George F. Lull, A.M.A. secretary and general manager, pointed out that the association is studying the consensus of the state representatives who attended the conference and will proceed in a manner consistent with the views of the majority.

This proposal to extend social security payments to the disabled was branded "strictly a political maneuver to influence votes" by Dr. Gunnar Gundersen, chairman of the A.M.A. Board of Trustees. "If the American people are going to retain their right to spend their money as they wish," he said in a press release, "they must stand up now and vigorously fight these super-Santa Claus proposals born of politics. The proposals contained in this bill actually provide an illusory benefit at the cost of ever-increasing taxation and loss of personal freedom."

Under the title of "Someone Must Pay," an editorial in the Chicago Daily News of July 20 commented on the House action taken "in a whooping anticipation of elections ahead." Observing that "as with all 'welfare' legislation, it is not a pleasant task to quarrel with kindly, humane proposals," it continued: "Barron's Weekly points out that in 1950, the Social Security system was paying an average of $21 monthly to some 2.9 million persons. By June, 1954, payments were being made to 6.5 million individuals, at an average monthly rate of more than $50.

Thus what started out as a modest program for a minimum pension of bare-sustenance proportions is mushrooming into a system promising a comfortable living for the retired, care for the disabled and dependent, and with increasing inequalities between contributions and benefits. . . .

"The advocate of caution in this progress has an ungrateful role, something like parading around the feast with a stomach pump. . . . The hard truth is that the government cannot pay money to one person without having previously taken it from him or some other person. The great popular appeal of Social Security, of course, rests upon the belief that somebody else is going to get the heavy end of the check. . . . It would be unthinkable for some future Congress to reneg on a contract sealed by the payment of taxes. But we also have no moral right to obligate future taxpayers to a burden that could become so great as to lower their own standard of living, while they pay for the generous but ill-advised impulses of their predecessors."

In similar vein, the Chicago Daily Tribune commented editorially on July 21 that the revisions passed by the House "represent a new low in the something-for-nothing game that the demagogs of the nation have been playing on the public since 1936." The editorial continued: "To the persons, about 1,300,000, affected by these new provisions, the payments will be largely velvet. They will contribute less and get more. But people who keep on working will be presented with a constantly increasing bill. . . . Experience shows, however, that when the time comes to increase these taxes, Congress will back down. . . . All that does is shift more of the burden to future generations.

"The man who retorted to a plea to think of posterity with the question, 'What did posterity ever do for me?' now has his answer. Posterity is going to pay his old age pension. Or will it?

"Posterity can vote, too, and the increasing burdens of social security are going to make it less popular politically as the taxes necessary to keep the system solvent mount higher and higher. That, of course, is of no consequence to the something-for-nothing Democrats in the house. They aren't looking for posterity's votes — only those of the 1,300,000 whose benefits, if the senate concurs, will be increased a few months before the polls open next year."

Said the Omaha World-Herald editorially on August 23: "It should be remembered that the Social Security contribution is a tax, not an insurance premium. It is not even a 'special' tax in any meaningful sense. What goes into the Social Security 'trust fund' is a Government bond. The money is paid into the general fund of the United States Treasury, and is spent for any purpose the Government spenders see fit.

"The bond amounts to an I.O.U. from the Government and when it comes time to pay the pensioners Uncle Sam will have to levy new taxes to pay the face amount. If that is not embezzlement, the difference is not very great."

With the second session of the 84th Congress opening early next month, every physician will need to be particularly alert to the issues involved and will wish to do all in his power to defeat unwise social security legislation and to educate the public to its dangers.

Midwinter Seminar in Ophthalmology and Otolaryngology

Miami Beach, Jan. 16-21, 1956

During the week of January 16, the University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology will be held in Miami Beach for the tenth successive year. As in recent years, the Sans Souci Hotel again will be the headquarters for this annual gathering, which attracts registrants from all sections of this country and several foreign countries. An innovation this year will be a rearrangement of the lecture schedule which will provide a maximum time for recreation each afternoon. There will be five lecture periods of 55 minutes each with a five minute interval between, beginning at 8:30 a.m. and concluding at 1:30 p.m.

The 1956 Midwinter Convention of the Florida Society of Ophthalmology and Otolaryngology will be the usual midweek feature on the afternoon of January 18. All registrants of the Seminar are invited to attend. They and their wives are also privileged to attend the annual informal banquet at 8 p.m. that night.

The lectures on Ophthalmology will be presented on Monday, Tuesday and Wednesday, January 16, 17 and 18. The lecturers and their subjects are: Dr. Francis Head Adler, Philadelphia, "Muscles," "Muscles: Vertical Deviations: Diagnosis and Treatment," and again "Muscles;" Dr. Arthur Gerard DeVoe, New York, three lectures on "Plastic Surgery;" Dr. Michael J. Hogan,

(Continued on page 490)

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San Francisco, "Management of Cataract Complications," "Diagnosis and Treatment of Congenital and Acquired Ocular Toxoplasmosis," and "Diagnosis and Treatment of External Ocular Tumors;" Dr. A. D. Ruedemann, Detroit, "Glandular Exophthalmos: Differential Diagnosis and Treatment," "The Cosmetic End Result of Enucleation With and Without the Use of the Implant," and "The Use of Irradiation Therapy in Ophthalmology with Special Reference to Gamma in Treatment of Cancer of the Lids and Beta in Treatment of Corneal Lesions;" and Dr. C. Wilbur Rucker, Rochester, Minn., "Occlusive Vascular Disease in the Practice of Ophthalmology," "Elevated Optic Discs," and "Ophthalmoscopic Clinic Covering Wide Disorders of the Fundus."

On Thursday, Friday and Saturday, January 19, 20 and 21, the lectures on Otolaryngology will follow. The lecturers and their subjects are: Dr. Frederick A. Figi, Rochester, Minn., "Lesions of the Mouth," "Juvenile Fibromas of the Nasopharynx," and "Malignant Tumors of the Nose and Accessory Sinuses;" Dr. Charles E. Kinney, Cleveland, "Hearing Impairments in Children," "Office Therapy in Ear Problems," and "Stapes Mobilization Versus Fenestration;" Dr. John R. Lindsay, Chicago, "Disturbances of the Swallowing Mechanism," "Cholesteatoma: How It Develops; Treatment," and "Menière's Disease: Differential Diagnosis and Management;" Dr. Bernard J. McMahon, St. Louis, "Discussion of Present Unstable Status of Antibiotics in Otolaryngology," "Discussion of Sinusitis in Children and Some of Its Complications," and "Value of Irradiation in Recurrent Nasal Polyposis;" and Dr. Lewis F. Morrison, San Francisco, "Supplemental Thyroid Therapy and Otolaryngology," "Recurrent Laryngeal Nerve Paralysis," and "Diagnosis and Treatment of Benign Lesions of the Vocal Cords."

A. M. A. Delegates Report on 1955 Annual Meeting

At the 1955 Annual Meeting of the American Medical Association in Atlantic City, the House of Delegates was not seated until Monday, June 6. For the two days preceding the convention, however, there were other programs of national interest to the delegates and the members. The first, held on Saturday, June 4, was the Third Annual National Medical Civil Defense Conference. This was an all day program lasting from 8:30 a.m. till 5:30 p.m. with the hour and a half period for lunch reduced to approximately 55 minutes.

Next, there was a motion picture presentation titled "The Flash of Darkness," which was presented by the Los Angeles County Medical Society. This picture was filmed for the program of "Medic," which is given on various television stations and also is going to be made available for showing in local motion picture houses in the near future. This was a dramatic portrayal of a doctor manning a Civil Defense emergency station, who was called in the midst of his office hours to man his station. Showing his disgust at being called out on another practice, he found that this time it was not a practice. The picture showed the patients brought through his emergency room, the communication difficulty, the flow of medical supplies, and the handling of the patients who came to his aid station and emergency hospital for a period of 24 hours. It will probably be available and be on the screen within six to eight months. It was a frightening picture.

We then had a symposium on trauma and mass casualty care by Army and civilian doctors. They emphasized that hospital staffs and institution personnel, normally thinking in terms of caring for four or five emergencies at one time, must think in terms of hundreds or thousands at one time. For example, assuming that your local hospital was not damaged, and keeping in mind what a turmoil three emergencies at one time can cause, imagine thinking in terms of a hundred or a thousand to be brought in within a short period of time. The emphasis here on mass casualty care made one feel he would almost have to unlearn his previous dictums of care of patients because it would be physically impossible to care for this number on a permanent basis at this time. Those who obviously would die within a short period of time are sent on, and nothing is done except to give opiates. For others needing care, the only care that is given at this

time is the stopping of hemorrhage and other such necessities, and then the patient is directed on until definitive care can be given 24, 36, or 48 hours later.

Next was a symposium on the problem of radioactive fall-out. This was first started off by Dr. Justin J. Stein, who is chairman of the Medical Military Affairs Committee, and the Civil Defense of the California Medical Association. He gave the plan of the radiologic defense in California. That state has spent a large sum of money on Civil Defense. It has several mobile laboratories set up, costing between $15,000 and $25,000. On short notice they can be sent to any part of the state where they might be needed for the detection of contamination by radioactive elements. Dr. Kinsman, a sanitary engineer, gave an interesting discussion on the contamination of food and water and how to detect what foods would be safe to eat and how to prepare those that were not. With regard to water, he stated that if water becomes contaminated, dig off the surface dirt and fill the water with a large amount of dirt, stir it up thoroughly and allow the dirt to settle; then pour off the water and the radioactive material would be taken out. Of course, then one would have to chlorinate the water or boil it to make it safe from a bacteriologic standpoint. Food that has been exposed to radioactivity should be treated as follows: For canned goods, wipe off the can thoroughly with a cloth soaked in warm soapy water, then open the can and pour out the contents. They would not be radioactive. By peeling carefully thick-skinned foods such as bananas and oranges, one could avoid getting radioactive contamination from them.

There followed a motion picture of a trial run of the Civil Defense Disaster Unit, Harris County, Texas, which includes Houston, on a supposed catastrophe that happened in Beaumont, Texas, 90 miles away. Three hospitals loaned all the equipment to be used. Medical students, tagged as different casualties, were sent on to be treated, and a certain number of local civilians in Beaumont were tagged as casualties. The authorities had set this up as an emergency civil defense disaster unit and had drills, and all knew what they were to do. They had trucks donated that were serving as transportation. The Texas Highway Patrol cooperated and all the police departments. They were notified of a disaster at 7 p.m. By 11 p.m. the first units had arrived, had set up and had started taking care of casualties. Two hundred and fifty thousand dollars worth of equipment was loaned and only fifty dollars worth was lost.

On Sunday afternoon there was the Conference of Presidents and Other Officers of State Medical Associations, of which Dr. Louis M. Orr, of Orlando, a past president, now serves on the executive committee. Dr. James R. Fox, of Minneapolis, an American physician who had practiced two years in England under its socialized plan, spoke on the many difficulties he encountered there. His main point was that British medicine is where it is today because of the British physicians' lack of interest in socioeconomic affairs and the laissez faire attitude of letting "George" do it, and "George" did it, but not to the liking of the doctors.

Next was an address on "The Backdoor to Socialized Medicine" by Senator John W. Bricker of Ohio, the author of the Bricker Amendment. There are three things that the Bricker Amendment will do: (1) prohibit treaties made in conflict with the United States Constitution, (2) make a treaty ineffective as internal law if it is in conflict with state laws, and (3) require a roll call vote for ratification. There is little disagreement regarding one and three. Number two is the only one about which there is controversy. In 1801, only 15 years after the Constitution was adopted, Thomas Jefferson considered this same issue and declared that "the Constitution must have meant to except out all those rights reserved to the states, for surely the President and the Senate cannot do by treaty what the whole government is interdicted from doing in any way." Senator Bricker said the prime legal issue raised by his amendment is: Can a treaty or other international agreement override the Constitution? The founding fathers never dreamed that this could happen. The theory that treaties stand on a level with the Constitution itself, or can alter or amend the Constitution, should not be allowed to develop or to exist. There must be no possibility of a one man law in the United States, even though such a law does not contravene any express constitutional prohibition.

There is already a treaty in effect in the United States whereby foreign physicians of certain countries can come to Florida and take the State Board examination despite the fact that our state law requires that they be citizens of the United States before being able to take it. This treaty

has overridden the state law of Florida, and the desire of the Bricker Amendment is for some protection against future presidents making treaties of this nature.

Another interesting speaker was Herbert Philbrick, who is the author of "I Led Three Lives" and also a television series of the same name. He brought out how easy it is for young people to become enmeshed in communist front organizations and become deeply involved before they know what they are in, some of them not knowing how to get out.

House of Delegates

The first meeting of the House of Delegates was held on Monday, June 6, at 10 a.m. There are 195 delegates, 166 from the state societies, one each from Alaska, Hawaii, the Canal Zone and Puerto Rico, 20 from the specialty sections and five from the government services, Army, Navy, Air Force, Public Health and Veterans Administration. The allotment of delegates to the state associations is one delegate for each thousand members or fraction thereof. The morning of this day was taken up with introducing distinguished guests and visitors from other countries and the reading of resolutions and reports of councils and committees. There were 83 resolutions presented that had to be read and referred to reference committees, besides the reports of each of the councils and the Board of Trustees. Also, a feature of this day was the selection of the recipient of the Distinguished Service Award for 1955. The three men nominated were Dr. Daniel C. Elkin, Atlanta, Ga., Dr. Donald C. Balfour, Rochester, Minn., and Dr. John R. Paul, New Haven, Conn. Dr. Balfour was elected for this honor.

Tuesday was the day that the various reference committees met to discuss the business that was presented to the House of Delegates in the form of reports of councils and committees and resolutions from component societies. There were 14 reference committees, and it was sometimes difficult to get around to the ones in which we were interested, or the particular subject that was going to be discussed.

Resolution No. 2, which was introduced for the Florida delegation by Dr. Francis T. Holland, was a request to the American Medical Association to re-examine its policy concerning veterans with wartime service suffering from tuberculosis of nonservice origin on the basis of a survey of existing civilian facilities. This resolution, introduced to the House of Delegates of the Florida Medical Association in St. Petersburg, was adopted there, and we presented it to the A. M. A. The reference committee for the A. M. A. recommended that the resolution be referred to the committee on Federal Medical Services of the Council on Medical Service for further study and evaluation.

Concerning the resolution on the administration's Omnibus Health Bill, it would (1) invade the field of private enterprise with additional tax-free federal corporations operating with tax money; (2) further circumvent congressional control over the national debt; (3) set up a dictatorial control over the entire field of health activities under the Secretary of Health, Education, and Welfare; (4) advance the efforts of those who would nationalize the insurance industry, and (5) further extend the federal activities into fields specifically reserved for the states by the Constitution. The House of Delegates adopted the recommendation of the reference committee in that there were six separate and distinct titles in the administration's Omnibus Health Bill referred to in the resolution. The Committee on Legislation of the A. M. A. is opposed to the first four of these titles, approves the fifth in principle with suggested amendments, and supports the sixth actively. With the consent of the representative of the Texas delegation, the reference committee recommended approval of the attitudes adopted by the Committee on Legislation of the A. M. A. with regard to the various segments of this bill.

In reference to dispensing of glasses by ophthalmologists and also the dispensing of drugs and appliances by other physicians, there were numerous resolutions introduced into the House. These were considered as one, and the recommendation of the reference committee, which was adopted by the House of Delegates, was that the existing Section 8, Chapter I of the Principles of Medical Ethics, which prohibited these activities be repealed, and the following be substituted in lieu thereof:

"It is unethical for a physician to suggest or request any person to have a prescription filled at a drugstore in which the physician has a financial interest or from which he may expect either directly or indirectly a pecuniary return. It is not unethical for a physician to dispense drugs or appliances except where the physician's financial interest in such dispensing is placed above the quality of medical care."

The resolution on the selection of the General Practitioner of the Year, introduced by Dr. Lester D. Bibler, the delegate from the Section on General Practice, recommended that the House of Delegates recommend to the various state societies to set up committees of general practitioners from their general practice sections, if such exist, and also that the recommendations of these committees be forwarded through their respective state associations to the Board of Trustees. Since this plan is essentially in effect at the present time, no action was taken; however, it was urged that the constituent associations nominate their outstanding general practitioner to compete for the General Practitioner of the Year.

There were several resolutions dealing with a directive of the United Mine Workers of America Welfare and Retirement Fund requiring consultation by a specialist before admission to a hospital of all beneficiaries of this program who are treated by physicians other than those approved by the U. M. W. A. Welfare and Retirement Fund as specialists. This example affords an insight into the encroachment of various labor organizations in attempting to dictate the practice of medicine. In Pennsylvania, in one or maybe several communities, the doctors went on a so-called strike. They did not refuse to see any of the patients; they would take care of them as private patients, but would not accept them as recipients of the miners' welfare fund. A substitute resolution was adopted which registered disapproval of this requirement and suggested that unresolved controversial matters be referred to the A. M. A.

The rest of the afternoon of that day was spent with the reference committee on the osteopathic question. Most of the delegates had received, a day or two before going to the meeting, a copy of the report of the Committee for the Study of Relations Between Osteopathy and Medicine. There were nine committee members who participated in the investigations of the osteopathic schools, and deans from three medical schools who acted as advisors in 1955. In the inspection of the schools, not all members of the committee inspected all schools. Only Dr. John W. Cline, the chairman, inspected all of the schools. There were other members, one or two, with him at each inspection, plus an advisor, who was a dean in a recognized A. M. A. approved medical school. This discussion lasted well into the afternoon.

The conclusions of the Cline report were as follows:

"1. Educational requirements for admission to colleges of osteopathy are identical to those of medical schools. Review of admission records would indicate a somewhat lower scholastic average, but practically all students would be eligible to admission to medical school if it were not for the high level of competitive standards in medical schools.

"2. Current curriculums in colleges of osteopathy include all subjects taught in present day schools of medicine. In addition, there are courses dealing with the musculoskeletal system and manipulative therapy. The degree of emphasis upon these courses is variable and is diminishing. At none of the colleges was there evidence that these courses interfered with the achievement of sound medical education.

"3. All osteopathic colleges face the handicap of insufficient financial support. In some colleges the proportion of operating funds derived from tuition and student fees is far too high.

"4. The teaching of some basic science courses is well done. Material improvement is needed in others.

"5. In some instances the clinical facilities and clinical material do not justify the numbers of students enrolled. These handicaps are being partially overcome and, when achieved, current plans of expansion will improve the situation. The major deficiency in clinical instruction is the lack of trained clinical teachers. It is difficult for graduates of colleges of osteopathy to obtain training which would fit them for teaching in clinical fields. These circumstances lead to an "inbred" faculty and impair teaching programs.

"6. The facts outlined in the three immediately preceding conclusions are recognized by the administrations, faculty members, and some students of the institutions visited. Considerable effort is being expended and some progress is being made in improving the situation. The administrative heads of the colleges expressed a real desire for the addition of good doctors of medicine to their faculties and for the opportunity for selected young graduates to obtain sound graduate training in medical institutions. They believe that the teaching programs in their colleges would be strengthened thereby and that their graduates would be better doctors. Improvement of clinical teaching is urgently needed.

"7. The teaching in present day colleges of

osteopathy does not constitute the teaching of 'cultist' healing.

"8. Postgraduate educational opportunities for doctors of osteopathy are extremely limited. If better postgraduate education were available, the level of patient care would be improved.

"9. The American Medical Association is dedicated to the purpose of improving the health and medical welfare of the American people. The osteopathic profession supplies medical care to millions of Americans. In many areas the only immediately available medical care is rendered by osteopaths.

"The American Medical Association must decide whether it will assist in improving the medical care rendered by doctors of osteopathy. The Committee believes that the only constructive course which can be followed is to enlarge the medical educational opportunities of the students and graduates of schools of osteopathy by elimination of the classification of teaching in colleges of osteopathy as the teaching of 'cultist' healing.

"The past osteopathy is unimportant. Its present, and particularly its future, are important to the medical care of the American people.

"10. The number of osteopathic physicians, the scope of licensure, the opportunities for practice, probably the level of practice, and the degree of interprofessional prejudices are extremely variable in different areas. It is obvious that no national policy governing the over-all relationship of doctors of medicine to doctors of osteopathy can be realistic. This should be a function of the several state medical associations and in certain states perhaps of the county medical societies." The recommendations of the committee were:

"1. That the House of Delegates declare that current education in colleges of osteopathy does not constitute the teaching of 'cultist' healing.

"2. That the House of Delegates declare the policy of the American Medical Association to be to encourage doctors of medicine to assist in osteopathic undergraduate and postgraduate medical educational programs in those states in which such participation is not contrary to the announced policy of the state medical association.

"3. That the House of Delegates request state medical associations to assume the responsibility of determining the relationship of doctors of medicine to doctors of osteopathy within their respective states or request their component county societies to do so.

"4. That this or a similar committee be continued to confer with representatives of the American Osteopathic Association concerning common or interprofessional problems on the national level."

Dr. Dwight L. Wilbur, of California, Chairman of the Reference Committee on Medical Education and Hospitals, presented the following majority report:

"Your reference committee, after a study of the report of the Committee for the Study of Relations Between Osteopathy and Medicine and the study of other evidence submitted, is not completely satisfied that the current education in colleges of osteopathy is free of the teaching of cultist healing.

"In view of the desire to elevate the standards of teaching in colleges of osteopathy, your reference committee recommends approval of the recommendation of the committee that doctors of medicine may accept invitations to assist in osteopathy undergraduate and postgraduate medical educational programs in those states in which such participation is not contrary to the announced policy of the respective county and state medical associations. Such teaching services would be ethical.

"Your reference committee approves the recommendation of the committee that the House of Delegates request state medical associations to assume the responsibility of determining the relationship of doctors of medicine to doctors of osteopathy within their respective states or request their component county societies to do so.

"Your reference committee recommends that a committee be appointed at the discretion of the Board of Trustees to confer with representatives of the American Osteopathic Association concerning common or interprofessional problems on the national level." It was moved by Dr. Wilbur, and the motion was seconded, that the majority report be adopted.

Dr. Milford O. Rouse, of Texas, a member of the reference committee, submitted a minority report, as follows:

"One member of the reference committee was completely satisfied that an appreciable portion of current education in colleges of osteopathy definitely does constitute the teaching of cultist healing, and is an index that the 'osteopathic concept' still persists in current osteopathic practice.

Since he cannot with good conscience approve the recommendation that doctors of medicine teach in osteopathic colleges where cultism is part of the curriculum, he respectfully makes the following recommendation to the House of Delegates:

"(1) That the report of the Committee for the Study of Relations Between Osteopathy and Medicine be received and filed, and that the committee be thanked for its diligent work and be discontinued.

"(2) That if and when the house of delegates of the American Osteopathic Association, its official policy-making body, may voluntarily abandon the commonly so-called osteopathic concept, with proper deletion of said 'osteopathic concept' from catalogs of their colleges, and may approach the Board of Trustees of the American Medical Association with a request for further discussion of the relations of osteopathy and medicine, then the said Trustees shall appoint another special committee for such discussion."

After discussion, the motion to adopt the majority report was amended to substitute the minority report for the majority report. After further discussion, the minority report of the reference committee on the report of the Committee for the Study of Relations Between Osteopathy and Medicine was adopted.

It was difficult to vote for either the majority or the minority report for the following reasons: The difficulty in voting for the majority report was found in Chapter 2, Section 1 of the Code of Medical Ethics regarding sectarianism or cultism, for the report stated that the osteopathic schools were not free from the teaching of cultist healing. Also, the House had previously passed resolutions forbidding the teaching in schools of optometry. The difficulty in accepting the minority report was that it recommended the committee's discontinuance in paragraph 1 and in paragraph 2 that the negative report be accepted rather than the positive approach of providing good medical care and improved medical care for all of the people of the country.

There was a resolution deploring the present method of establishing service connections for various diseases by legislative fiat without individual evaluation.

There were several resolutions presented from various delegations regarding dissatisfaction with the present Joint Commission on the Accreditation of Hospitals. They were carefully studied, but it was thought that not enough information was available at this time, and the Speaker of the House of Delegates was requested to appoint a special committee to review the functions of the Commission and report back at the meeting in one year.

The resolution regarding pediatric residency training was referred to the Council on Medical Education and Hospitals for further study and evaluation.

There has been a special committee of the House of Delegates studying, for some time, the possibility of making a requirement for a certain amount of general practice prior to specialization. The report of this committee was quite lengthy and very interesting. The committee had received replies to questionnaires sent out to 9,600 certified specialists. Over 90 per cent of those who had had previous experience in general practice prior to becoming specialists and 40 per cent of those specialists who had had no experience in general practice prior to certification considered it valuable training and recommended a year or two of such experience prior to specialty certification for all young doctors. Today, 40 per cent of all doctors in active practice in this country are listed as certified specialists, to say nothing of the unlisted specialists; so undoubtedly, better than 50 per cent of the doctors are specialists in one of the many branches of medicine. Until about three years ago, the great majority of senior medical students indicated that they planned upon graduation to go directly into specialization; however, the present trend in medical education, namely, "farming out" senior medical students temporarily with general practitioners in the preceptorship type of training has somewhat altered this picture. This is a problem that cannot be solved by a resolution at the moment because of the long range planning and change that must be necessary. It would involve the problem of internships as well as residencies of some 19 specialties and about 25 subspecialties, and it would be necessary to get the cooperation of the specialty boards before anything could be done.

The Board of Trustees was asked to have the Committee on General Practice Prior to Specialization revised to become an 11 member committee to include three members of the Board of Trustees, two members of the Council on Medical Education and Hospitals, two members of the Council on Medical Service, and four members from the House of Delegates, two of whom are general practitioners, and none of the 11 mem-

bers to be deans or full time professors in medical schools or officers or directors of any specialty board. It was further recommended that the committee be made responsible to the Board of Trustees and make periodic reports to it and the House. In addition, it was recommended that the committee be instructed to work in close liaison and cooperation with the Council on Medical Education and Hospitals and the Council on Medical Service in bringing about, at the earliest date possible, such changes as are needed to provide for recent graduates of medical schools to have one or more years' general practice actual experience prior to the time they are certified by a specialty board.

There was some discussion regarding moving of the headquarters of the A. M. A. from Chicago to Washington, where it can be on the scene at the site of national government in view of the increasing complexity of government involving medicine. This suggestion was discussed at length, but the move doubtless will not take place. Probably the A. M. A., however, because of crowding of its building in Chicago, will get out of the printing and binding business and contract for its publications with some printing company. This plan should give adequate space in the Chicago building. The delegates are to visit the building in groups at the meeting in Chicago next June.

The Board of Trustees' report on Guides for Grievance or Mediation Committees gave evidence of much study. The Board concluded, however, that there were not sufficient data at the present time to put out a guide that would be adequate for all states. It hopes to have this guide ready for the Boston meeting, but it may be next summer before it is available.

The Board of Trustees' report on the Hoover Commission stated that the A. M. A. is in hearty accord with the basic philosophy which permeates the recent Hoover Commission report in its efforts (1) to increase efficiency in government, (2) to promote economy and eliminate waste, (3) to promote decentralization in government and effect elimination of reduplication, and (4) promote elimination of federal functions that compete with private business and industry.

With regard to the Committee on Legislation of the A. M. A., not much can be said right now with regard to what is taking place in the Congress. It behooves every member to read the Journal of the American Medical Association each week regarding the legislative activity and legislative committee report. Through June approximately 10,000 bills were introduced into the Congress. Of this number, 314, or roughly 3 per cent, are of primary interest to physicians. A divided leadership of the executive and legislative branches of the federal government, as well as the discovery by both parties of the political appeal of health measures, seems to account for the increased legislative activity. Major proposals on which the A. M. A. has been heard in the House of Representatives include mental health, medical aspects of the reserve forces bill, draft deferment of scientific specialists, "doctor draft" law, military medical scholarships and military physician's "incentive pay." Those on which it has been heard in the Senate include mental health, research construction grants, vocational education of practical nurses, water pollution control, air pollution control, medical school construction grants and the Bricker Amendment. The Association has not been successful in all of its interests, but has been successful enough to take courage in what it is doing and to continue on a more vigorous and active basis getting back to the grass roots. There will be legislative conferences in six strategically located areas of the United States this fall. The one for this area will be held in Atlanta on November 6, which is a Sunday, and all members of the A. M. A. are invited to attend, especially those of local legislative committees.

A new study by the Council on Medical Service with regard to the policy of medical practice by full time teachers in medical schools is under study, the resolution having been introduced by Dr. J. P. Culpepper Jr. of Mississippi at the Miami meeting. The committee is still engaged in this study and hopes to have a report at the Boston Meeting.

It is recommended strongly that state and county medical associations be urged to participate aggressively in their Civil Defense programs.

Dr. Walter B. Martin, the retiring president, gave an excellent address regarding his stewardship of the office and urged the individual doctors to continue the support of medical education financially through the American Medical Education Foundation. The doctors of America must further encourage voluntary health insurance, but they must also be watchdogs in preventing abuses which, if allowed to continue and develop, will eventually weaken its effectiveness and destroy it. They must continually search for better methods of caring for the uninsurable group of people and

ways of giving them adequate medical care. "Conditions under which medicine is practiced have changed radically, but the basic philosophy of medicine has not changed," Dr. Martin stated. "Our obligation is to bring the best that medicine can offer to the individual patient. . . . Good medicine . . . must deal with individuals and not with masses alone. Unfortunately, it is held by many that mass production and the ballyhoo of the carnival can meet the medical needs of the people. This concept often finds expression in the political field with poorly conceived and ill-directed legislative proposals." In conclusion, he predicted: "The future of medicine will be secure and can be as glorious as its past if we uphold the principles that have made it great today and that have made it one of the most beneficent forces that moves in this modern world."

Dr. Elmer Hess, President-Elect, in his opening address reiterated Dr. Martin's problem of getting coverage for the lower income and no income group of the American people. He pointed out that he thought the doctors of America should take an active part in combating the slaughter and needless bloodshed on the American highways in that there are many license-carrying motorists who are temperamentally and physically unfit to drive and should be weeded out. In a closing paragraph Dr. Hess said: "The two meetings which we hold each year to discuss the policies of the Association are just as important as are the scientific meetings. We furnish for the scientists a forum where they may debate the issues so important to the clinical application of the various types of medical research. The House of Delegates has the duty only to decide policies at a national level. These really have little to do with science per se, but have a great deal to do with our relationship with each other, with other organizations and the public. The real test of our national policies must be based on the confidence the people have in each of us as we go about our daily task of ministering to the sick and unfortunate."

The House adopted a statement presented by the Reference Committee on Medical Education and Hospitals which included the rule called the "one-fourth rule" providing that any internship program which in two successive years does not obtain one-fourth of its stated complement be disapproved for intern training.

The House adopted a resolution directing that hereafter the nondelegate representatives from each state medical association and the head of each scientific section receive all written material which the delegates receive. This provision is urgently needed. Mr. Gibson and/or Mr. Parham in future will receive this information so that the delegates, when requesting any information, will not have to give up their copies to them for reference. Also, it is urgently needed that the A. M. A. permit the executive secretary or managing director of state medical associations to have a room in the headquarters hotel in order that the delegates may use him to the fullest advantage.

The President-Elect of the A. M. A. is Dr. Dwight H. Murray, Napa, Calif., a general practitioner. Dr. Louis M. Orr, of Orlando, Florida's senior delegate, was elected to the office of Vice-Speaker of the House of Delegates and resigned from his position on the Council on Medical Service. Dr. Reuben B. Chrisman Jr., of Miami, was elected to Dr. Orr's place on the Council on Medical Service.

Respectfully submitted,
Louis M. Orr, M.D.
Reuben B. Chrisman Jr., M.D.
Francis T. Holland, M.D.

Hospital Services for the Indigent

In April 1954, the House of Delegates of the Florida Medical Association authorized the Board of Governors to request the Governor of Florida to appoint a committee to study the problem of hospitalization of the indigent in Florida, and to make recommendations for a legislative act to assist with hospitalization for these indigent.

A citizens' committee was appointed by Governor LeRoy Collins, and a careful study of the problem was made. The recommendations of the committee appeared in the June 1955 issue of The Journal of the Florida Medical Association on page 1028.

The legislature passed House Bill No. 336 during the last day of its 1955 session in June of this year. The law takes effect Jan. 1, 1956. This law was intended to help the counties provide hospitalization for the acutely ill or injured indigent patient who can be helped markedly by treatment in a hospital. The sum of $3,000,000 was requested of the legislature for the state's share of the cost of the program for the biennium. Because of inadequate funds, however, the legis-

lature was able to appropriate only $500,000 for the 18 month period beginning Jan. 1, 1956.

The law designates the State Board of Health to administer the program and directs it to adopt rules and regulations, including the development of a formula for the allotment of state funds on a matching basis with participating counties.

Detailed plans for the operation of the program are being prepared at the present time. In order for a county to share in the state funds it is necessary that the county appropriate at least 50 cents per capita per year. The state's allotment to the county may not exceed 50 per cent; however, with the present appropriation the state's contribution will be considerably below 50 per cent. Studies are now being made to determine how many counties could qualify at present since many of them are already contributing more than 50 cents per capita.

When the program is placed in operation, the physician that first sees the patient will be the person to help determine if the patient is medically indigent and in need of hospitalization. The county health department, when necessary, will make a more definite check as to the indigence unless this responsibility is delegated to other persons such as the local welfare representative. The patient will then be referred to the hospital that will accept such patients. Hospitals accepting these patients must have not less than 10 beds and be approved by the State Board of Health.

As stated, this service is intended only for the hospitalization of patients who are acutely ill or injured, and indigent. It does not include patients requiring long hospitalization, such as those with tuberculosis, complicated orthopedic conditions, or any chronic illness.

Members of the Hospital Service for the Indigent Advisory Committee are H. Phillip Hampton, M.D., Tampa, Chairman, Edward Jelks, M.D., Jacksonville, Mr. Pat Groner, Pensacola, Mr. Richard Simpson, Monticello, and Mr. Frank Kelly, Miami.

This program operates differently from the State Cancer Program in that the counties have to contribute in order to participate in the state funds; however, the State Cancer Program requires no contribution on the part of the county. Studies are being made to consider the possibility of merging some of the state's hospitalization programs.

This program does not provide for the payment of fees to any physician rendering service to those indigent patients receiving hospitalization.

It is believed that most physicians will want to support this program because physicians have always done more than their share in providing medical care for the patients who are unable to provide it for themselves. This program originated with the physicians. It should make it easier for the physician to take care of the indigent patients as he always has in the past. The bill as passed by the legislature was prepared and recommended by the Association's Committee on Legislation and Public Policy. Dr. Hampton and his committee were most active in the support of this bill, and congratulations are certainly due them for their part in attaining this step toward providing medical care for the indigent of our state.

As the plans for the operation of the program are developed, further announcements will be made.

Graduate Medical Education Diabetes Association Meeting Held

The Florida Clinical Diabetes Association held its third annual meeting at the Princess Issena Hotel in Daytona Beach on October 20 and 21, 1955. The Florida Academy of General Practice also met at the same hotel the following two days, and several of this group attended the meeting of the Diabetes Association. Assistance in preparing the program and securing the lecturers was given by the Department of Medicine of the Graduate School of the University of Florida, the Florida State Board of Health, and the Committee on Medical Postgraduate Course of the Florida Medical Association.

Both Dr. Joseph T. Beardwood Jr., Professor of Diseases of Metabolism in the Graduate School of the University of Pennsylvania, Philadelphia, and Dr. Franklin H. Epstein, Assistant Professor of Medicine in Yale University School of Medicine, New Haven, Conn., brought to the group the latest in research as well as the most recent methods of handling patients with diabetes mellitus. The lectures were well received by the physicians in attendance, for they broadened the concept of the great amount of research being carried out in an effort to determine the etiology of the disease, now recognized as never having been established, and they delineated clearly the improved methods of treatment.

One of the most gratifying features of the program was the excellent papers presented by the members of the Diabetes Association. The public meeting was held on Friday night with a good attendance of laymen interested in the subject. More than half of those present indicated that they had active diabetes. Dr. Beardwood, Dr. Epstein, and Dr. Egbert V. Anderson, of Pensacola, spoke at this meeting, which was moderated by Dr. Lawrence J. Schneider of the Volusia County Medical Society. Those interested in this disease are of the opinion that these meetings are of great benefit to the general public.

The newly elected officers are: President, Dr. Richard H. Sinden, of St. Petersburg; President-Elect, Dr. Edward R. Smith, of Jacksonville; and Secretary-Treasurer, Dr. George H. Garmany, of Tallahassee. The next meeting is scheduled for October 1956 in Jacksonville. The present plan is to devote the second day to diseases of metabolism, thus offering information to physicians not necessarily interested in diabetes mellitus.

The Nation's Stake in Medical Education

This country today has the largest turnout of graduating physicians, more approved medical schools than ever before, the largest medical student enrolment in history, the greatest increases in medical teaching facilities, and the highest operating costs. Likewise, the budgets are the biggest ever. There were, in 1954, 28,277 students enrolled in 80 schools of medicine while in 1910 only 12,530 students were enrolled in 66 schools. All medical schools now are fully approved by the American Medical Association and the Association of Medical Colleges. Obviously, the nation as a whole has such a tremendous stake in medical education that it is entitled to a factual appraisal of the situation which confronts it. These facts will be welcomed by the public and also by physicians. Certainly they refute the current myths that medical schools fail to keep enrolments and graduates at a level commensurate with the rate of growth of the population, and other doubts and misconceptions as well.

American medicine has a great heritage in which to take pride. The present era of unprecedented progress is in large measure the outgrowth of a changed intellectual climate in medicine resulting from the reforms in medical education effected by the Flexner Report of 1910. Recently Dr. W. Barry Wood Jr. declared this changed attitude to be the most important medical advance of this century.[1,2] If there is merit in the thesis that the developments in medical education during the last 45 years have had a major role in the unparalleled progress of medicine during these years, then what of today's medical schools and their future?

Not alone in America, but throughout the world medical schools are in dire need of more income. Since 1900 the cost of running American medical schools has increased 1,000 per cent. In 1910 tuition fees covered 70 per cent of the expenses of medical education;[1] in 1954 income from tuition constituted but 19.5 per cent of the basic operating budget.[3] At the present time it costs approximately $10,000 to $12,000 to train a physician, yet the student's total four year tuition averages only $2,532. Other sources of income are state appropriations, for state schools only, alumni contributions, endowments, and grants. In addition, two organizations raise funds from voluntary sources. The National Fund for Medical Education obtains funds from corporations and organized groups and is now leading a nationwide appeal to raise $10,000,000 annually for the country's medical schools. Last October former President Herbert Hoover received the Frank H. Lahey memorial award "for outstanding leadership in medical education" because of his long and active work with this group. The American Medical Education Foundation raises money from within the medical profession. Since 1951 the two groups have raised almost $7,000,000 to assist the schools.

The economic inflation of the forties, which increased operating costs almost 100 per cent, is partly responsible for the present financial plight of the medical schools. Other contributing factors are the very advances in methods of teaching and diagnostic and therapeutic technics and the provision of better facilities for the care of patients growing out of ever progressing American medicine. In one recent year more than half of this country's medical schools ran deficits totaling $10,000,000. How long can this trend continue?

If the downward spiral toward insolvency is not somehow checked, financial disaster obviously lies ahead. "Just what would such an eventuality mean?" asks Dr. Wood. "It would bring an end to the training of fully qualified physicians.

Without competent doctors, the practical gains of medical research, which have been so striking during the last fifty years, would be virtually lost. Health services would deteriorate, and diseases now effectively controlled would once more plague the populations of the world."

Federal aid is not the answer. The medical profession welcomes one-time federal grants for medical school construction and renovation and federal grants for special research in diseases. Wisely, however, it opposes continuing federal aid lest the government seek to control that which it finances. Medical education and research have advanced in this country because they have been free, and they must be kept free. They can flourish only in an atmosphere in which creative initiative is unrestricted. One of the greatest contributions the American physician can make to medicine and to the public good is to render swift and adequate financial support to medical education. If he would prevent the entrance of political influence into medical education, he must act promptly and effectively on a broad front to carry his share of the load.

The stakes in the financial struggle for the survival of medical education are indeed extraordinarily high. They involve, as Dr. Wood observed, the very welfare of society, for "if science and education are the brain and central nervous system of civilization, health is its heart." Medical educators are confident that once the needs become widely enough known, increased private funds will be made available to their schools. Nevertheless, the crucial question to be answered is, "How much of its assets will modern society be willing to invest in its health? Certainly there will be a limit, and the nature of this limit may determine, more than any other single factor, the future of medicine."

1. Wood, W. B. Jr.: Medical Progress Since 1900, International Forum, vol. 3, no. 4, in Therapeutic Notes 62:103-106 (April) 1955.
2. Keynote of Twentieth Century Medical Progress, J. Florida M. A. 42:206-207 (Sept.) 1955.
3. What's Up with Our Medical Schools? American Medical Association pamphlet, 1955.

Medical District Meetings, 1955

The sixteenth annual Medical District Meetings were held October 10 at Fort Lauderdale, October 11 at Lakeland, October 12 at Gainesville and October 14 at Pensacola. Total registration for the four meetings was 323 members of the Florida Medical Association and 59 visitors.

Scientific subjects for the meetings in Fort Lauderdale and Lakeland were the same. The tittles of addresses were "Medical Aspects of Jaundice," "Surgical Aspects of Jaundice" and "Problems in Use of Blood and Blood Substitutes."

For the meetings in Gainesville and Pensacola, the subjects were "Blood Transfusions," "Plasma and Plasma Expanders," "Blood Substitutes" and "Blood Transfusions and Reactions" in addition to the addresses on the medical and the surgical aspects of jaundice.

Guest scientific speakers for the meetings were Dr. George T. Harrell Jr., of Gainesville, dean of the College of Medicine, University of Florida, and Dr. James J. Griffitts, of Miami, president-elect of the American Association of Blood Banks and associate director of the John Elliott Blood Bank of Dade County. Dr. Homer F. Marsh, dean of the University of Miami School of Medicine, was a guest at each meeting.

Other speakers on the scientific programs were Dr. Charles L. Wadsworth, of Fort Lauderdale; Dr. John H. Mickley, of Hollywood; Drs. William W. Trice Jr. and Charles Catanzaro, both of Tampa; Dr. Ashbel C. Williams, of Jacksonville; Dr. Oscar W. Freeman, of Orlando; Drs. Walter C. Payne Jr., Jack W. Fleming and Gerard H. Hilbert, of Pensacola, and Dr. George H. Garmany, of Tallahassee.

Dr. Ralph W. Jack, of Miami, chairman of the Council, presided at both the scientific assembly and the general session of each of the four meetings. Assisting him were the district councilors.

Dr. John D. Milton, President; Dr. Francis H. Langley, President-Elect, and Dr. Samuel M. Day, Secretary-Treasurer, were present at all the meetings and gave short talks. Dr. Webster Merritt, assistant editor of The Journal, reported on the progress of The Journal at the meetings in Lakeland and Gainesville.

Workshop sessions were arranged at each district meeting for the ladies of the Woman's Aux-

iliary under the leadership of Mrs. Samuel S. Lombardo, of Jacksonville, president.

Southeast Medical District

October 10 — Fort Lauderdale

Dr. Ralph W. Jack, chairman of the Council, presided at the meeting and was assisted during the scientific assembly by Dr. Ralph S. Sappenfield, councilor for District 8, and at the general session by Dr. James R. Sory, councilor for District 7.

The address of welcome was delivered by Dr. Ernest E. Serrano, president of the Broward County Medical Association. Following this address, Dr. George T. Harrell Jr. discussed the "Medical Aspects of Jaundice;" Dr. Charles L. Wadsworth "Surgical Aspects of Jaundice," and Drs. James J. Griffitts and John H. Mickley "Problems in Use of Blood and Blood Substitutes."

The 1956 meeting will be held in West Palm Beach. Total registration was 98, of which 80 were Association members (D District 73) and 18 visitors. Among those attending the meeting were past presidents Edward Jelks, Robert B. McIver, Walter C. Jones and Homer L. Pearson Jr.

Registration

BELLE GLADE: Wilbert O. Norville (Col.). DANIA: Fred E. Brammer, Melvin M. Stone. FORT LAUDERDALE: Louis L. Amato, Norris M. Beasley, Miles J. Bielek, Mark Butler, Milton N. Camp, Russell B. Carson, Eugene E. Christian (Col.), Alfred E. Cronkite, James W. Dickey Jr., Burns A. Dobbins Jr., Frederick J. Driscoll, Robert L. Elliston, Frederick W. Fisher, Roland F. Fisher, E. Borland Gill, Walter J. Glenn Jr., George Hamerick Jr., Benjamin F. Hart, Anne L. Hendricks, Paul W. Hughes, Garland M. Johnson, Richard A. Mills, Richard D. Owen, Henry J. Peavy Sr., William K. Peck, Francis D. Pierce, Lees M. Schadel Jr., Paul G. Shell, Curtis H. Sory, Robert G. Talley, Willard M. Taylor, Charles L. Wadsworth, James M. Weaver, W. Dotson Wells, Scottie J. Wilson. GAINESVILLE: George T. Harrell Jr. HIALEAH: Oliver D. Anderson. HOLLYWOOD: Dale T. Anstine, Andre S. Capi, Gordon B. Carver, John H. Mickley, Louis J. Novak, Bernard B. Seltzer, Ernest E. Serrano. JACKSONVILLE: Samuel M. Day, Edward Jelks, Robert B. McIver, Wilson T. Sowder. LAKE WORTH: Arthur T. Rask. MIAMI: Reuben B. Chrisman Jr., Edward W. Cullipher, L. Washington Dowlen, James J. Griffitts, Ralph W. Jack, Walter C. Jones, Donald F. Marion, John D. Milton, Homer L. Pearson Jr., Hunter B. Rogers, Walter W. Sackett Jr., Ralph S. Sappenfield, Corren P. Youmans. MIAMI SHORES: Jesse C. McMillan. ORLANDO: Robert E. Zellner. POMPANO BEACH: George S. McClellan. ST. PETERSBURG: Francis H. Langley.

VERO BEACH: Kip G. Kelso. WEST PALM BEACH: Joseph J. Daversa, Hugh Dortch Jr., John H. Dyett (Col.), W. Ambrose McGee, Ralph M. Overstreet Jr., Cecil M. Peek, Vitol S. Shepard, James R. Sory, Governor M. Witt.

VISITING DOCTORS—ATLANTIC CITY, N. J.: David B. Allman. FORT LAUDERDALE: Beverly R. Birely, Roger K. Haugen, Malcolm E. Miller, John I. Williams. HOLLYWOOD: David J. Lehman Jr., Sidney J. Peck. PHILADELPHIA, PA.: John Tomlinson. POMPANO BEACH: Paul E. Gutman, Francis J. McNally, Paul T. Menzies.

OTHER GUESTS—CHICAGO, ILL.: Tom Hendricks. CORAL GABLES: Homer F. Marsh, Ph.D. JACKSONVILLE: Ernest R. Gibson, Eugene L. Nixon, W. Harold Parham, H. A. Schroder. MIAMI: John C. Lee.

Southwest Medical District

October 11 — Lakeland

Assisting Dr. Jack as presiding officers for the meeting were Dr. James R. Boulware Jr., councilor for District 6, during the scientific assembly, and Dr. C. Frank Chunn, councilor for District 5, at the general session.

Following the address of welcome by Dr. Samuel J. Clark, president of the Polk County Medical Association, Dr. Harrell discussed the "Medical Aspects of Jaundice;" Dr. William W. Trice Jr. "Surgical Aspects of Jaundice," and Drs. James J. Griffitts and Charles Catanzaro "Problems in the Use of Blood and Blood Substitutes."

The 1956 meeting place chosen at the general session is Tampa. Total registration was 114 of which 95 were Association members (C District 85) and 19 visitors. Past presidents in attendance were Edward Jelks, David R. Murphey Jr., and Robert B. McIver.

Registration

ARCADIA: Henry P. Bevis, Gordon H. McSwain, Anthony D. Migliore. BARTOW: Alfred S. Massam, John H. Miller, William F. Peacock. BRADENTON: Irving E. Hall Jr., Willis W. Harris, Richard V. Meaney, John S. Neill, Millard P. Quillian, Henry E. Rasmussen-Taxdal, Marvin Silver. BREWSTER: Gerald W. Grawey. CLEARWATER: Douglas W. Carr, Robert L. Neil. DUNEDIN: John A. Mease Jr., James F. Spindler, Walter H. Winchester. FORT LAUDERDALE: Russell B. Carson. FORT MYERS: Ernest Bostelman. GAINESVILLE: George T. Harrell Jr. HAINES CITY: Emmett E. Martin. JACKSONVILLE: Samuel M. Day, Edward Jelks, Robert B. McIver, Wilson T. Sowder. LAKELAND: Robert M. Akey, Clarence L. Anderson, Jere W. Annis, Clyde E. Asbury Jr., William M. Bevis, James R. Boulware Jr., Clyde E. Clark, S. Allen Clark, Samuel J. Clark, James M. Clayton Sr., I. Graydon Cloud, John E. Daughtrey, Fred I. Dorman Jr., Howard M. DuBose, Henry Fuller, Ralph B. Hanahan, William A. Hodges Jr., John M. Kibler, Everett S. King, Coy L. Lay, William P. Logan, Louis J. Polskin, Walter C. Price, James T. Shelden, Henry M. Stern, S. L. Watson, James R. West, John W. Williams. LAKE WALES: Willard E. Manry Jr., MIAMI: Ralph W. Jack, John D. Milton. MULBERRY: John A. Ray. ORLANDO: William S. Mitchell, Robert E. Zellner. ST. PETERSBURG: Clyde O. Anderson, N. Worth Gable, James L. Gouaux, Henry J. Jensen, John B. O'Neill, Benjamin H. Sullivan. SARASOTA: James E. Kicklighter, Melvin M. Simmons. SEFFNER: Myrtle Sweimler. TAMPA: Ernest R. Bourkard, Leffie M. Carlton Jr., Frank V. Chappell, C. Frank Chunn, Robert H. Coffer Jr., Herschel G. Cole, Richard G. Connar, Rosalind E. Cummings, J. Brown Farrior, Chas. McC. Gray, H. Phillip Hampton, Warren T. Loftis Jr., Eugene B. Maxwell, David R. Murphey Jr., Julien C. Pate Jr., Zack Russ Jr., Alan J. Stevenson, William W. Trice Jr., Walter H. Wellborn Jr., Wesley W. Wilson,

James A. Winslow Jr., Robert W. Withers. WINTER HAVEN: Newell J. Griffith, Theodore C. Keramidas, Howard C. Lucas.

VISITING DOCTORS—LAKELAND: Malcolm B. Burris, John P. Collins, Gordon R. Heath, Albert M. Hyde, Charles W. Inman, Albert G. King Jr., Wayne O. Montgomery. LAKE WALES: Townsend S. Pennington. ST. PETERSBURG: James O. Fergeson. TAMPA: Charles Catanzaro, Thomas H. Garth, Arturo G. Gonzalez. WINTER HAVEN: Arthur J. Moseley Jr.

OTHER GUESTS—CORAL GABLES: Homer F. Marsh, Ph.D. JACKSONVILE: Ernest R. Gibson, Eugene L. Nixon, W. Harold Parham, H. A. Schroder. LAKELAND: Robert B. Eleazer.

Northeast Medical District

October 12 — Gainesville

During the scientific assembly, Dr. Jack was assisted as presiding officer by Dr. Charles L. Park Sr., councilor for District 4, and at the general session by Dr. Henry J. Babers Jr., councilor for District 3.

Dr. Edwin H. Andrews, president of the Alachua County Medical Society, delivered the address of welcome immediately prior to discussion of the "Medical Aspects of Jaundice" by Dr. Harrell. Following Dr. Harrell on the program was Dr. Ashbel C. Williams whose subject was "Surgical Aspects of Jaundice." Dr. James J. Griffitts' address was on the subject "Blood Transfusions," and Dr. Oscar W. Freeman's "Plasma and Plasma Expanders."

At the general session, Ocala was selected as the meeting place for 1956. Total registration was 114, of which 99 were Association members (B District 91) and 15 visitors. Among those registered were past presidents Edward Jelks, Robert B. McIver, Eugene G. Peek Sr., Duncan T. McEwan and Herbert E. White.

Registration

APOPKA: Thomas E. McBride. ARCHER: Frank C. Jones. CASSELBERRY: Stuart P. Culpepper. COCOA: Lee Rogers Jr. CRESCENT CITY: Bernard E. Kane. DAYTONA BEACH: John J. Cheleden, Herbert A. King, Beverly H. White. DeLAND: Lancaster C. Starke (Col.). FERNANDINA: Henry B. Dickens Jr. FORT LAUDERDALE: Russell B. Carson. GAINESVILLE: Chester F. Ahmann, Edwin H. Andrews, Henry J. Babers Jr., F. Emory Bell, Billy Brashear, Alva T. Cobb Jr., John A. Crago, Eugene H. Cummings, Allen Y. Delaney, J. Maxey Dell Jr., George L. Emmel, Charles H. Gilliland, Henry H. Graham, Frank M. Hall, Edward L. Hamilton, George T. Harrell Jr., Albert G. Love IV, Cecil E. Love, James M. McClamroch, John E. Maines Jr., Harry M. Merchant, Walter E. Murphree, George H. Putnam, Stuart D. Scott, DeWitt T. Smith, Thomas A. Snow. JACKSONVILE: S. James Beale, James L. Borland, Frederick H. Bowen, J. Brooks Brown, Turner Z. Cason, James E. Cousar III, Samuel M. Day, Joseph W. Eversole, A. Judson Graves, Vernon T. Grizzard Jr., Ivan Isaacs, Karl B. Hanson, Edward Jelks, F. Gordon King, Louie Limbaugh, Samuel S. Lombardo, James G. Lyerly, Charles F. McCrory, Robert B. McIver, Webster Merritt, Bernard L. N. Morgan, Clarence D. Rollins, E. Thomas Sellers, Wilson T. Sowder, John T. Stage, Sidney Storch, George M. Stubbs, William A. Van Nortwick, Donald P. White Jr., Ashbel C. Williams. LAKE CITY: Robert B. Harkness. LEESBURG: Marion B. O'Kelley. MIAMI: James J. Griffitts, Ralph W. Jack, John D. Milton. NAPLES: Ethel H. Trygstad, Reidar Trygstad. NEWBERRY: George W. Karelas. OCALA: Bertrand F. Drake, Robert L. Gibson, Eugene G. Peek Sr., Eugene G. Peek Jr. ORLANDO: Thomas R. Collins, Oscar W. Freeman, Harold W. Johnston, Lawrence H. Kingsbury, Duncan T. McEwan, Fred Mathers, Roger E. Phillips, Louis E. Pohlman, Breckinridge W. Wing, Robert E. Zellner. PALATKA: Grover C. Collins, James A. Long Jr. (Col.), Alfred P. Peretti. ST. AUGUSTINE: Reddin Britt, Herbert E. White. ST. CLOUD: James C. Rinaman. ST. PETERSBURG: Francis H. Langley. SANFORD: J. Clifford Boyce, Charles L. Park Sr., George H. Starke (Col.).

VISITING DOCTORS — CLERMONT: Carl M. Smith. GAINESVILLE: Ernest R. Casey Jr., Henry W. Deurloo, James G. Wilson. JACKSONVILE: James W. Bond, James M. Davis, Joel J. White. LAKE CITY: Oliver W. Greer. COLUMBIA, S. C.: Andrew H. Miller.

OTHER GUESTS—CORAL GABLES: Homer F. Marsh, Ph.D. GAINESVILLE: David Kuhner, Ph.D. JACKSONVILE: Ernest R. Gibson, Eugene L. Nixon, W. Harold Parham, H. A. Schroder.

Northwest Medical District

October 14 — Pensacola

Dr. Harrell was moderator for the subject jaundice and Dr. James J. Griffitts for blood during the scientific assembly, and presiding with Dr. Jack was Dr. William P. Hixon, councilor for District 1. Serving with Dr. Jack at the general session was Dr. Walter J. Baker, councilor for District 2.

Following the address of welcome by Dr. George W. Morse, president of the Escambia County Medical Society, Dr. Walter C. Payne Jr. discussed the "Surgical Aspects of Jaundice." Following Dr. Payne's address, Dr. George H. Garmany and Dr. Griffitts spoke on the subject "Medical Aspects of Jaundice." "Blood Substitutes" was the subject of an address by Dr. Jack W. Fleming, and Dr. Gerard H. Hilbert discussed "Blood Transfusions and Reactions."

The 1956 meeting will be in Tallahassee. Total registration was 56, of which 49 were Association members (A District 46) and 7 visitors. Among those registered were past presidents Herbert L. Bryans and Walter C. Payne Sr.

Registration

FOLEY: Walter J. Baker. GAINESVILLE: George T. Harrell Jr. JACKSONVILLE: Samuel M. Day. MARIANNA: Courtland D. Whitaker. MIAMI: James J. Griffitts, Ralph W. Jack, John D. Milton. PANAMA CITY: John J. Benton, William C. Roberts. PENSACOLA: Egbert V. Anderson, John J. Baehr, Paul F. Baranco, Barkley Beidleman, Charles R. Benton, Herbert L. Bryans, William M. Colmer Jr., Jack W. Fleming, Samuel D. Gillespie Jr., Henry O. Heath, Howard E. Herring Jr., William P. Hixon, Alpheus T. Kennedy, Sidney G. Kennedy Jr., Albert Lehmann, John J. McGuire, John C. McSween Jr., Noel C. Mellen, George W. Morse, Wendell J. Newcomb, John M. Packard, Charles A. Patterson, William T. Patton, Walter C. Payne Sr., Walter C. Payne Jr., Samuel B. D. Rhea, Winfred E. Ryle, Lee Sharp, Earl M. Spaulding, Raymond B. Squires, Alvin L. Stebbins, Wilton E. Tugwell, Alvyn W. White, Dale E. York. ST. PETERSBURG: Francis H. Langley. TAL-

(Continued on page 508)

OTHERS ARE SAYING

Editorial

Malpractice insurance is too expensive. Premiums have been raised within the last three years, and there is another request for increased premiums before the Florida State Insurance Board. Previous requests for raises in the premiums have been denied by the State Insurance Arbiter, only because of vigorous efforts by the state medical society and by the various county medical societies.

The reasons for the increased cost of malpractice insurance are many. First, juries have become over-generous with compensation paid for damages in accident and personal liability cases. The expense to the insurance companies in such cases is therefore correspondingly high. Fortunately, malpractice insurance suits do not fall into the same category. It is very seldom that an insurance company pays compensation for malpractice. The writer knows of no such cases in recent years in Florida. However, the cost of interviewing interested parties and collecting evidence remains high.

Secondly, there is a tendency for the physician who is sued to want to avoid the effects of the adverse publicity in his practice. This results in some cases being settled out of court at the expense of the insurance company. Such settlements result in money being paid for claims which are essentially without merit. We should, perhaps, place more faith in the American judicial system and in the common sense of juries than we do. There should be a closer liaison between the medical profession and the legal profession. A step in the right direction has been taken by the appointment of committees in the Medical County Society and in the Legal County Society to work out a standard method of procedure in medico-legal cases. Perhaps this can be followed later by closer social relations, and in time, it may result in physicians losing some of their phobias about courts.

Thirdly, it is possible for the doctors to get their own house in better shape. We all know of incidents which happen in our practice which could result in suits. Has any person ever turned an ankle when coming off your examination table? Has anyone ever bruised a shin in your waiting room? If such incidents were reported to the proper committee — not necessarily to the Grievance Committee because they are not grievances — but to an Insurance Committee who would investigate, mediate between doctor and patient and recommend what action should be taken and what form of redress the patient should have if redress is justified, such procedure might result in minimizing the number of potential lawsuits against a physician, and therefore the cost of investigating evidence and in the end, should reduce the cost of our malpractice premiums.

This committee has not been appointed pending the receipt of this article by the membership of the county society. If enough of you agree with me that such a committee would perform a useful function, it will be appointed.

I am told that one of the great insurance companies has carried about twenty-five percent of the membership of the Dade County Medical Society for malpractice, at a cost of about eight hundred dollars for the last three years. Such figures are not consistent with the insurance companies' request for higher malpractice premiums.

E. S.

—The Record, Broward County Medical Association
October 1955

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Faircloth, Robert S., Fort Lauderdale
Fisher, Frederick W., Fort Lauderdale
Greene, Joseph L., Hialeah
Herrero, Blas C., Miami
Kahn, Charles J., Pensacola
Kaufman, Arthur L., Miami
Mann, Ronald J., Miami
Miale, John B., Miami
Multach, David, Miami Beach
Myers, Andrew L. Jr., Lake Wales
Ortiz, Arturo C., Miami
Rogers, Wayne S., Hialeah
Rowland, Harold T., Miami
Snyder, Clifford C., Miami
St. Mary, Edward W., Miami
Stone, Melvin M., Dania
Strozier, Thomas B., Miami
Talcott, LeRoy E. Jr., Miami
Trappolini, Alma, Miami
Underwood, Russell S., Miami
Vinoski, Bernard B., Miami
Zundell, Warren, Coral Gables

STATE NEWS ITEMS

Dr. James N. Patterson of Tampa returned from Chicago the latter part of October where he assisted with examinations of the American Board of Pathology and attended the meetings of the American Society of Clinical Pathologists.

Dr. Lorenzo L. Parks of Jacksonville has been elected president of the Florida Public Health Association.

Dr. L. Roland Young of Daytona Beach attended the Sixth Annual Institute of the Graduate School of Medicine, University of Pennsylvania, the latter part of September. "Advances in Medicine and Surgery and Allied Specialties" was the program with emphasis in the specialties placed on endocrinology and neuropsychiatry.

Dr. Patrick J. Lynam of Cocoa attended the annual meeting of the American Academy of Ophthalmology and Otolaryngology held in Chicago the middle of October.

Dr. Walter B. Tomlinson of Pensacola was principal speaker at an October meeting of the Pensacola Kiwanis Club. The subject of his address was heart ailments.

Dr. Harold H. Fox of Miami Beach has returned from Philadelphia where he attended a meeting of the International College of Surgeons.

Dr. John M. Packard of Pensacola delivered a paper before the Southeastern Regional Meeting of the American College of Physicians held at Charleston, S. C. He reported on electrocardiogram abnormalities based on research with 2,600 students in Escambia county.

Dr. Ernest C. Johnson Jr. of Pahokee discussed "Improved Practices in Modern Medicine" at a recent meeting of the Pahokee Rotary Club.

Drs. Eugene L. Jewett and Peter B. Wright of Orlando were principal speakers at the 16th annual meeting of the American Fracture Association held the latter part of September at Miami Beach.

Dr. Bernard M. Barrett of Pensacola attended the recent meeting of the American Academy of Ophthalmology and Otolaryngology held at Chicago.

Dr. Joel V. McCall Jr. of Daytona Beach attended the American Medical Academy of Cerebral Palsy held in Memphis the middle of October under a scholarship awarded him by the Volusia County Parents Group for Physically Handicapped Children.

Dr. Walter W. Sackett Jr. of Miami has been elected president of the Dade County Chapter of the American Academy of General Practice. Serving with Dr. Sackett will be Dr. Manning J. Rosnick, vice president; Dr. Robert C. Piper, secretary-treasurer, and Dr. Leon S. Eisenman, a member of the board of directors.

Dr. Gretchen V. Squires of Pensacola has been appointed by the Escambia County Commission to the position of county medical director.

Dr. Franz H. Stewart of Miami was one of the principal speakers at the Southern Tuberculosis Conference held recently at Louisville, Ky. The subject of his address was "Tuberculosis and Pregnancy."

Dr. Irwin S. Leinbach of St. Petersburg has been relating his experiences in Europe at public lectures held in Trinity Evangelical and Reformed Church at St. Petersburg the early part of the fall season.

Dr. Francis A. Reed of Miami Beach addressed by invitation the recent meeting of the American College of Physicians held at Charleston, S. C.

Dr. Ivan Isaacs of Jacksonville has been elected president of the North Florida Radiological Society. Chosen at the October meeting to serve with him as secretary was Dr. Marvin H. Johnston, also of Jacksonville.

Dr. Pascal G. Batson Jr. of Pensacola has been selected by the First Baptist Church there to lead its 1956 Every Member Canvas.

Dr. Jack T. Bechtel has announced the opening of his office at 228 Eighth Avenue, Indialantic, Fla., for the practice of cardio-vascular disease and internal medicine.

Dr. Thomas H. Maren of Stamford, Conn., has been appointed professor and head of the Department of Pharmacology and Dr. Joshua L. Edwards, professor and head of the Department of Pathology at the College of Medicine, University of Florida. Both appointments became effective Dec. 1. Dr. Edwards is a native of Jasper and attended the public schools of Lake City. He was assistant in the Department of Pathology and Microbiology at the Rockefeller Institute for Medical Research.

The State Polio Advisory Committee has approved the use of Salk vaccine in the age group 1-15 inclusive and in all prenatal cases, according to Dr. Richard G. Skinner, chairman of the Florida Advisory Committee on Salk Vaccine. The supply of vaccine being provided by Federal funds may be obtained through the local county health director. If this supply of vaccine is to be used, the necessary records required can also be obtained from the health director at the same time the vaccine is obtained.

Dr. William H. McCullagh of Jacksonville has been chosen president-elect of the Southern Psychiatric Association.

Dr. Clarence M. Sharp of Jacksonville was one of the speakers at the Southern Tuberculosis Conference held recently at Louisville, Ky. The title of his address was "Non-Tuberculous Disease Found in Case Finding Surveys."

Drs. Lucien Y. Dyrenforth and Nelson A. Murray of Jacksonville were among the group of Florida physicians who attended the annual meetings of the American Society of Chinical Pathologists and the College of American Pathology held the latter part of October in Chicago.

Dr. John T. Stage of Jacksonville addressed a recent meeting of the Northeast District Dental Society held at Atlantic Beach.

Dr. Marvin V. McClow of Jacksonville attended the annual meeting of the American Roentgen-ray Society held in Chicago in September.

Drs. Samuel M. Day, Lorenzo L. Parks, Wilson T. Sowder, Wilbur C. Sumner and Ashbel C. Williams of Jacksonville were among the group of physicians from throughout the state who attended the annual meeting of the Florida Division of the American Cancer Society held recently at Redington Beach.

Dr. Russell V. Douglas of Orlando entered medical service with the U. S. Army on May 8, 1955, with the rank of major.

Drs. Richard A. Bagby, Sherman B. Forbes, J. Brown Farrior, Ned W. Holland, Anthony P. Perzia and Joseph W. Taylor Jr. of Tampa attended the recent meeting of the American Academy of Ophthalmology and Otolaryngology held in Chicago.

Dr. Franklin J. Evans of Coral Gables has been appointed a member of the Florida Bar Committee on Cooperation with Professional Groups in the state.

Dr. Wray D. Storey of Tampa attended the joint meeting of the College of American Pathology and the American Society of Clinical Pathologists held in Chicago.

Dr. William H. Everts of West Palm Beach was principal speaker at the October meeting of the Y Men's Club of that city.

Dr. Fred A. Vincenti of Mount Dora has been elected first vice president and Dr. LeRoy H. Oetjen secretary of the Lake County Unit of the American Cancer society.

Dr. William C. Blake of Tampa attended the recent meeting of the American College of Physicians at Charleston in his capacity as governor of the College in Florida.

Drs. Oren A. Ellingson, S. Roy Higginbotham, A. M. C. Jobson, Julien C. Pate Sr., Julien C. Pate Jr., Lee T. Rector and Joseph N. Torretta of Tampa have returned from Philadelphia where

they attended the meeting of the International College of Surgeons.

Dr. John D. Browning of Ft. Pierce attended the October meeting of the National Association for Retarded Children held at Houston, Texas.

Dr. W. Tracy Haverfield of Miami has been elected chairman of the Florida Medical Committee for Better Government. Mrs. Richard F. Stover, also of Miami, has been chosen as secretary and Dr. Charles F. Henley of Jacksonville treasurer. District chairmen are Drs. Thomas E. McKell, Tampa; O. E. Harrell, Jacksonville; James T. Cook Jr., Marianna; Francis W. Glenn, Miami; C. Robert DeArmas, Daytona Beach; Alvin E. Murphy, Palm Beach; Jere W. Annis, Lakeland, and Dr. J. Maxey Dell Jr., Gainesville.

Dr. Floyd K. Hurt of Jacksonville was principal speaker at a late October meeting of the Rotary Club of that city. His address was one of the series being presented on vocational services.

COMPONENT SOCIETY NOTES

Bay

The Bay County Medical Society has paid 100 per cent of its state dues for 1955.

Broward

The Broward County Medical Association has paid 100 per cent of its state dues for 1955.

Duval

Dr. N. Chandler Foot, professor of pathology at the Cornell University Medical College and pathologist to New York Hospital, New York City, was principal speaker at the November meeting of the Duval County Medical Society. The title of his address was "Cytodiagnosis—Importance and Clinical Application in General Medicine."

Dade

The scheduled program for the November meeting of the Dade County Medical Association was a discussion of "Select Problems of the Legal and Medical Professions." Speaking for medicine was Dr. Homer L. Pearson Jr., moderator, and Dr. Herbert W. Virgin Jr. The legal aspect was discussed by Dr. Ben J. Sheppard, vice chairman, Florida Bar Committee on Cooperation with Professional Groups, and Joseph A. Boyd Jr., chairman of the Committee.

Hillsborough

Sir Harold Scott, recently head of Britain's Scotland Yard, was guest speaker at the November meeting of the Hillsborough County Medical Association. Invited guests for the meeting were the members of the Pinellas, Polk, Manatee and Sarasota County Medical Societies.

Lake

Dr. and Mrs. Sanford C. Colley of Mount Dora were hosts for the Lake County Medical Society's October meeting at their summer home on Lake Norris. A fellowship hour followed boating, swimming and a barbecue dinner. The program was "Relations — Public and Otherwise" with about fifteen members of the Society contributing.

Sarasota

The Sarasota County Medical Society has paid 100 per cent of its state dues for 1955.

Marion

Dr. John T. Stage of Jacksonville and Mr. H. A. Schroeder, executive director of Blue Shield of Florida, were principal speakers at the October meeting of the Marion County Medical Society. Their discussion centered around Blue Shield's new service benefits which are to be adopted after January 1.

In place of the November meeting, the Society held its annual sea food supper at Magnolia Lodge on Crystal River.

Medical Officers Returned

Dr. M. Crego Smith, who entered military service on February 20, 1955, was released from active duty on August 24, 1955 with the rank of major, U. S. Air Force. His address is 1016 Ponce de Leon Blvd., Clearwater.

Dr. Harry F. Taliaferro, who entered military service on February 22, 1953, was released from active duty on February 21, 1955 with the rank of captain, U. S. Air Force. His address is 1111 Tangerine St., Clearwater.

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1. Ruffin, J. M.; Baylin, G. J.; Legerton, C. W., Jr., and Texter, E. C., Jr.: Mechanism of Pain in Peptic Ulcer, Gastroenterology *23*:252 (Feb.) 1953.

2. Schwartz, I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: A Clinical Evaluation of a New Anticholinergic Drug, Pro-Banthine, Gastroenterology *25*:416 (Nov.) 1953.

SEARLE

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BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Richard G. Skinner Jr. of Jacksonville announce the birth of a daughter, Dorothy Barker, on October 2, 1955.

Dr. and Mrs. Douglas R. Murphy of Venice announce the birth of a son, Douglas R., Jr., on October 6, 1955.

Dr. and Mrs. Samuel E. Kaplan of Venice announce the birth of a son, Robert Samuel, on October 1, 1955.

Marriages

Dr. Henry C. Hardin Jr. of Miami and Mrs. Margaret Ann Richbourg were married September 29, 1955, in St. Augustine.

Deaths — Other Doctors

Randall, George M., St. Petersburg ... Sept. 20, 1955
McIver, Samuel C. (Col.), St. Petersburg ... April 16, 1945
Campbell, Franklin E., Jr., St. Petersburg ... Oct. 17, 1955

(Continued from page 502)

LAHASSEE: Frank E. All, George H. Garmany, Francis T. Holland, Nelson H. Kraeft, John L. Lincoln.

VISITING DOCTORS—PENSACOLA: Fariss D. Kimbell Jr.

OTHER GUESTS—CORAL GABLES: Homer F. Marsh, Ph.D. JACKSONILLE: Ernest R. Gibson, Eugene L. Nixon, W. Harold Parham, H. A. Schroder. TALLAHASSEE: Mel Snead.

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OBITUARIES

William Clarence Chowning

Dr. William Clarence Chowning of New Smyrna Beach died at Fish Memorial Hospital in that city on June 24, 1955, after a prolonged illness. He was 74 years of age.

A native of Virginia, Dr. Chowning was born at Merry Point on Nov. 13, 1881, and lived during his youth in Lancaster County. His ancestors had lived in Virginia since about 1680. He received his medical training at the University of Maryland School of Medicine and College of Physicians and Surgeons and was awarded the degree of Doctor of Medicine in 1904. He attended the fiftieth reunion of his class in 1954.

Dr. Chowning was licensed to practice in Florida in 1906. He located first in Hawthorne and later in Daytona Beach before moving in 1911 to New Smyrna Beach, where he engaged in the general practice of medicine for more than 40 years. A civic and social leader through the years, as well as a city and state official, he had held office in many organizations and in his church. He was a member of the City Commission from 1923 to 1928 and served as mayor from 1925 to 1928, a period of important paving, sewage and street lighting improvements. In the 1931 and 1933 legislative sessions he was state senator from Volusia County. For some years he was a member of the County School Board. A charter member, director and past president of the Kiwanis Club, he was also a member of the Elks Club, Odd Fellows Lodge and the Chamber of Commerce. For 40 years he served on the board of deacons of the Christ Congregational Church. He was active for years in the local Lawn Bowling Club until ill health recently prevented his participation in the sport.

At the time of his death Dr. Chowning was honorary chief of staff at Fish Memorial Hospital, an institution for which he had done much of the advance work and planning. He was examining physician for the Florida East Coast Railway, a post he had held longer than any other physician. Prior to and during World War II he served as examining physician for the Selective Service Board, and during the war when the younger physicians were in the service, he and the late Dr. L. B. Bouchelle took on many additional duties which taxed men of their ages.

Dr. Chowning was the oldest practicing physician in Volusia County. He was a member of

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Franz J. Ingelfinger, M.D., Boston, Mass. Gastroenterology
John I. Brewer, M.D., Chicago, Ill. Gynecology
S. Gilbert Blount, Jr., M.D., Denver, Colo. Internal Medicine
Eugene A. Stead, Jr., M.D., Durham, N.C. Internal Medicine
John H. Talbott, M.D., Buffalo, N. Y. Internal Medicine
Lawrence S. Kubie, M.D., New York, N. Y. Neuropsychiatry
Duncan E. Reid, M.D., Boston, Mass. Obstetrics
Frank W. Newell, M.D., Chicago, Ill. Ophthalmology
Claude N. Lambert, M.D., Chicago, Ill. Orthopedic Surgery
A. C. Hilding, M.D., Duluth, Minn. Otolaryngology
Alan R. Moritz, M.D., Cleveland, Ohio Pathology
Joseph A. Johnston, M.D., Detroit, Mich. Pediatrics
Philip J. Hodes, M.D., Philadelphia, Pa. Radiology
Arthur H. Blakemore, M.D., New York, N. Y. Surgery
Charles G. Child, III, M.D., Boston, Mass. Surgery
Rubin H. Flocks, M.D., Iowa City, Iowa Urology

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the Volusia County Medical Society and had twice served as its president. A life member of the Florida Medical Association, he recently had been accorded honorary status. He also held membership in the American Medical Association.

Surviving are the widow, Mrs. Mary B. Chowning, of New Smyrna Beach; one son, John S. Chowning, of Miami; two daughters, Miss Virginia Chowning, of Cocoa, and Mrs. Hamilton Lowell, of Miami, and two grandchildren.

Emory West Bitzer

Dr. Emory West Bitzer of Hernando died in a Tampa hospital on June 7, 1955, at the age of 72 years. A retired Tampa physician, he had lived there since ill health caused him to give up his practice in 1949. Interment took place in the Ocala Cemetery.

Dr. Bitzer was born in Taylorstown, Va., on Sept. 12, 1882. A descendant of pioneer families of Virginia, he received his education in his native state. Upon completion of his medical training at the University of Virginia Department of Medicine, he was awarded the degree of Doctor of Medicine in 1903. He then became athletic director and medical advisor at Washington and Lee University, Lexington, Va., and in 1907 received the Bachelor of Arts degree from that institution.

Denied the career he sought in the Medical Corps of the United States Army because of asthma, he came to Florida that same year, locating in Tampa, where he continued to practice medicine until he retired more than four decades later. He was the first physician in the Tampa Bay area to confine his practice to internal medicine and also to employ the sphygmomanometer and the electrocardiograph in the diagnosis and management of disease. Through the years he served on the staff of the various local hospitals, including Bayside Hospital, St. Joseph's Hospital, Tampa Municipal Hospital, and Clara Frye Tampa Municipal Negro Hospital. Locally, he was a member of St. Andrews' Episcopal Church, and after retirement to his lake home at Hernando he became affiliated with St. Margaret's Episcopal Church of Inverness, which he served as senior warden. The organ which he was instrumental in getting for this church will be dedicated to his memory.



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Dr. Bitzer was a member and past president of the Hillsborough County Medical Association. He was a life member of the Florida Medical Association and also held membership in the American Medical Association, Southern Medical Association, American Heart Association, and American College of Physicians.

The widow, Mrs. Elizabeth Hocker Bitzer, of Hernando, survives. Also surviving are one daughter, Mrs. Palmer Tuthill Jr., of Homestead; one son, E. W. Bitzer Jr., University of Virginia Department of Medicine, Charlottesville, Va.; his mother, Mrs. L. G. Bitzer, of Tampa; one sister, Mrs. Alvin Magnon, of Tampa; and three grandchildren.

Claude Anderson

Dr. Claude Anderson of Fort Myers died at Fort Myers Beach on July 28, 1955. He was 56 years of age. Interment took place in Orlando.

A native of Marshfield, Mo., Dr. Anderson moved to Orlando with his family in 1910. He was graduated from the old Orlando High School, where he was a star athlete. He received his undergraduate training at the University of Florida and was awarded the degree of Doctor of Medicine at the Jefferson Medical College of Philadelphia in 1927. Under a fellowship, he then studied at the Lahey Clinic in Boston.

In 1934, Dr. Anderson began the practice of medicine in Orlando. He entered military service in 1941 and served with the Navy in the South Pacific as a flight surgeon aboard an aircraft carrier. Upon discharge in 1947, he spent a year in graduate study at the University of Miami and then practiced in Fort Lauderdale until 1950. Returning to military duty at that time, he served as chief surgeon at Thule Air Force Base, Greenland, until 1953 when he joined the staff of Osceola Hospital in Kissimmee. He continued to practice there until he located in Fort Myers about a year ago.

Dr. Anderson was a member of the Orange County Medical Society and since 1927 had been a member of the Florida Medical Association. He also held membership in the American Medical Association. His specialty was surgery.

Survivors include his mother, Mrs. Jennie E. Anderson, of Orlando; two brothers, Bryan G. Anderson, of Eustis, and Dr. Frank Anderson, of Federalsburg, Md.; two sisters, Mrs. Eugene Pullen, of Tampa, and Miss Pauline Anderson, of Orlando; and a half-brother, Leon Anderson, of Jacksonville.



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Clarence Robert Wilcox

Dr. Clarence Robert Wilcox of Jacksonville died at his home on Aug. 2, 1955. He was 76 years of age.

Dr. Wilcox was born in Mayville, N. Y., on Feb. 15, 1879. Upon graduation from Jamestown High School, Jamestown, N. Y., he received his academic education at Hobart College and Wesleyan College, Middleton, Conn. He was awarded the degree of Doctor of Medicine by the University of Michigan Medical School on Jan. 15, 1904. He was a member of the Psi-Upsilon fraternity. Prior to his medical training he served in the Spanish-American War.

Coming to Florida soon after graduation to engage in the general practice of medicine, he received his state license on Oct. 19, 1904. He first practiced in Palatka and then in Clearwater, where he was Assistant Public Health Officer. In 1912, he located in Jacksonville, and was associated with Dr. Raymond C. Turck. Later, he was associated with Dr. George M. Mitchell, Dr. Thomas S. Field and the late Dr. J. Knox Simpson. He served on the staff of St. Luke's, St. Vincent's and the Duval County hospitals until his retirement from active practice in 1946. He was a founder of the Timuquana Country Club, where he enjoyed golf, his favorite sport.

Dr. Wilcox was a member of the Duval County Medical Society and a life member of the Florida Medical Association, holding honorary status at the time of his death. He also held membership in the American Medical Association and the Southern Medical Association.

Surviving are two daughters, Mrs. Stockton Broome Jr., of Atlanta, Ga., and Mrs. Walter H. Marshall, of Jacksonville; and four grandchildren, Stockton and Betsy Broome, of Atlanta, and Cynthia Brown and Terry Marshall, of Jacksonville.

BOOKS RECEIVED

Perinatal Mortality in New York City; Responsible Factors. A Study of 955 Deaths by the Subcommittee on Neonatal Mortality, Committee on Public Health Relations, The New York Academy of Medicine, Analyzed and Reported by Schuyler G. Kohl, M.S., M.D., Dr. P.H. Pp. 112. Price, $2.50. Published for The Commonwealth Fund by Harvard University Press, Cambridge, Massachusetts, 1955.

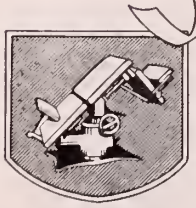
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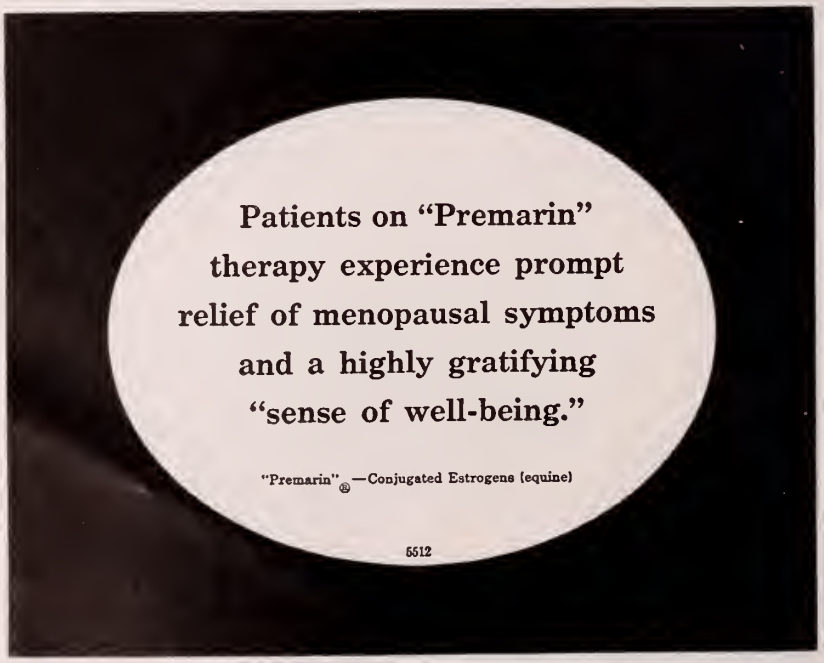
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that shortcomings in their care or lack of the best possible care were responsible for the death of one third of these infants. Of house staffs, obstetricians and "other" physicians caring for the mothers and infants, house staffs were associated with the greatest number of preventable deaths and the obstetricians with the lowest number. The fewest preventable deaths occurred in voluntary teaching hospitals and the largest number in nonteaching municipal hospitals. Toxemias of pregnancy are reported to have occurred in the mothers of 16 per cent of the infants in the study. This complication was most frequent among those whose babies were born dead. In the opinion of the Subcommittee on Neonatal Mortality, about half of that group could have been saved. High mortality was associated with births in which some type of operation or manipulation had been performed; an estimated 40 per cent of the deaths associated with cesarean operations could have been prevented by wiser use of the procedure.

Such findings as these will be of great interest to physicians in general and to obstetricians and pediatricians in particular, to federal, state, and local departments of health and to the United States Public Health Service; to medical schools and schools of social service; and to hospitals. This book is the second and final report based on a study undertaken in 1948 by The New York Academy of Medicine, Committee on Public Health Relations, at the request of the Bureau of Child Hygiene of the New York City Department of Health, of which Dr. Leona Baumgartner, the present Commissioner of Health, was then chief.

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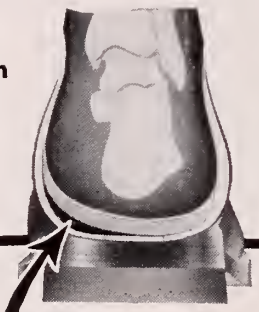
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Chit Chat from the Auxiliary

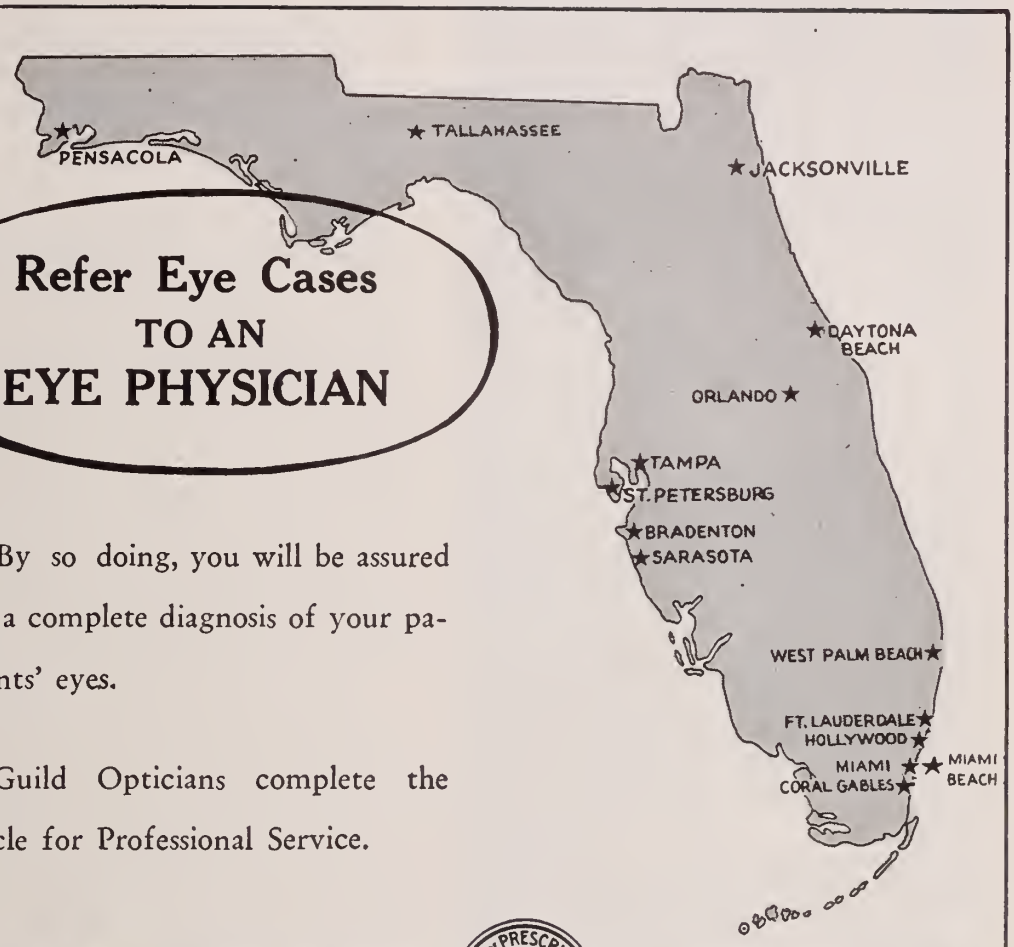
Since this is the last article in 1955 for The Journal of the Florida Medical Association, we thought you might be interested in some of the accumulated material we haven't as yet had time to write about. The major problem of writing for the Florida Medical Journal is the enormous amount of material to be written about and the limited time and space that one has to write in. So here goes to clean up some of the items we think are important. I suppose this article could be called the yearly clean-up article.

Following the national convention last June in Atlantic City at which the president, Mrs. Samuel S. Lombardo, discussed the health insurance pamphlets the Florida Auxiliary put out last year, 12 states have written to her asking for further information and samples, and inquiring how they, too, could use these pamphlets. Mrs. Lombardo has seen that this information was sent to them.

Last year a request was received from the Managing Director of the Florida Medical Association for a survey on the cooperation of medical associations with state auxiliaries. This survey was carried on during September, October, November and December of 1954 and the results were sent to him in January 1955. It necessarily meant contacting the presidents of the 47 other state auxiliaries. Since June at the national convention, your writer has received some 15 requests for the results of the survey and with the consent of the president of the Woman's Auxiliary to the American Medical Association, she has made a condensed report followed by a detailed report, state by state, and it will be sent to all states for their use.

Your writer now has on her desk a request for information on how the Dade County Health Fair was set up and how it worked, this Health Fair having been held in conjunction with the AMA Clinical Session in Miami last year. This is one of several requests of this sort and it will be answered in detail in order to help those interested in health fairs.

The district workshop meetings of our state auxiliary, held in conjunction with the district meetings of the Florida Medical Association, have proved of interest to our own members and also to officers and members of other state auxiliaries. Numerous requests have been received asking about them. With the success we have enjoyed



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in the immediate past workshops of October 10, 11, 12 and 14th at Fort Lauderdale, Lakeland, Gainesville, and Pensacola respectively, we have much to tell other states about our workshop meetings. Mrs. Samuel S. Lombardo attended all four of the district workshop meetings in her capacity as president of the Florida Medical Auxiliary and Mrs. Scottie J. Wilson, president-elect, attended the workshop meetings in Districts D and C. Reports show that this auxiliary project is growing in popularity and worth every year.

Mrs. Lombardo and Mrs. Wilson were present at the National Conference of State Presidents, Presidents-elect and National Chairmen held in Chicago on November 1, 2 and 3. Mrs. Lombardo was one of the panel speakers on public relations. Mrs. Richard F. Stover, national chairman for Mental Health, moderated the mental health panel. This Conference takes the place of meetings which would be held during the AMA Clinical Session since no auxiliary meetings are scheduled at this mid-year session.

Speaking of the mid-year session of the AMA, Floridians at the national convention last June were minutely questioned on what we did during the clinical session held in Miami last year. Representatives from Massachusetts told us that the reports were so favorable that they would have a hard time having as good a meeting in Boston. Of course, we were pleased but coming from Florida we realize we have something in climate and glamor to offer with which not many parts of the country can compete.

Our new auxiliary to the St. Lucie-Okeechobee-Martin County Medical Society is well on its way to being a strong and integral part of our state auxiliary. One of the projects they found need for was our Future Nurses Clubs. One has been organized at Fort Pierce High School and we hear they had 51 girls at the first meeting.

Palm Beach County Auxiliary, stressing mental health this year, has bought a screen for the Palm Beach County Mental Health Association and is buying a movie projector as well as encouraging other organizations to buy films to build a library for educational purposes.

Escambia County Auxiliary organized four Future Nurses Clubs last year and have added two more this year. They find interest in nursing in the high schools of their county to be high and they are able to help in obtaining students for the nursing schools throughout the southern states.

Florida Auxiliaries as a whole have done such an excellent job this year on our Doctor's Day Programs that although this is being written prior to the convention of the Southern Medical Auxiliary, we are sure that Florida will rank high in her participation in this Southern Auxiliary Project.

Pinellas County Auxiliary is already making plans for setting up and helping out with our second Future Nurses Club State Meeting which will be held in St. Petersburg on March 16 and 17. The girls in the Clubs from over the state are looking forward to this meeting and are busy earning their own money for transportation and registration. Last year we had 16 new Clubs and we have added 15 more this year. We will have close to 50 by the end of our year in May.

Today's Health subscription lists are being sent to our auxiliaries and the same support Florida has given to promoting positive health information and public relations through Todays Health is looked forward to again this year.

The auxiliary interest in Program, Public Relations, Legislation, Mental Health, American Medical Education Foundation, Civil Defense, Southern Auxiliary, Nurse Recruitment and all other projects waxes high and though this article was to clean up the odds and ends of the year, space and time again limit us. We couldn't possibly clean it all up in one article for never a day passes that something new and exciting doesn't happen in auxiliary. Neither a clean-up item or chit chat is the following wish of every doctor's wife in Florida to her doctor husband and to the other doctors of the state: A MERRY CHRISTMAS AND A NEW YEAR FILLED WITH PEACE, CONTENTMENT, HAPPINESS AND GREAT PERSONAL SATISFACTION TO EACH AND EVERY ONE OF YOU.

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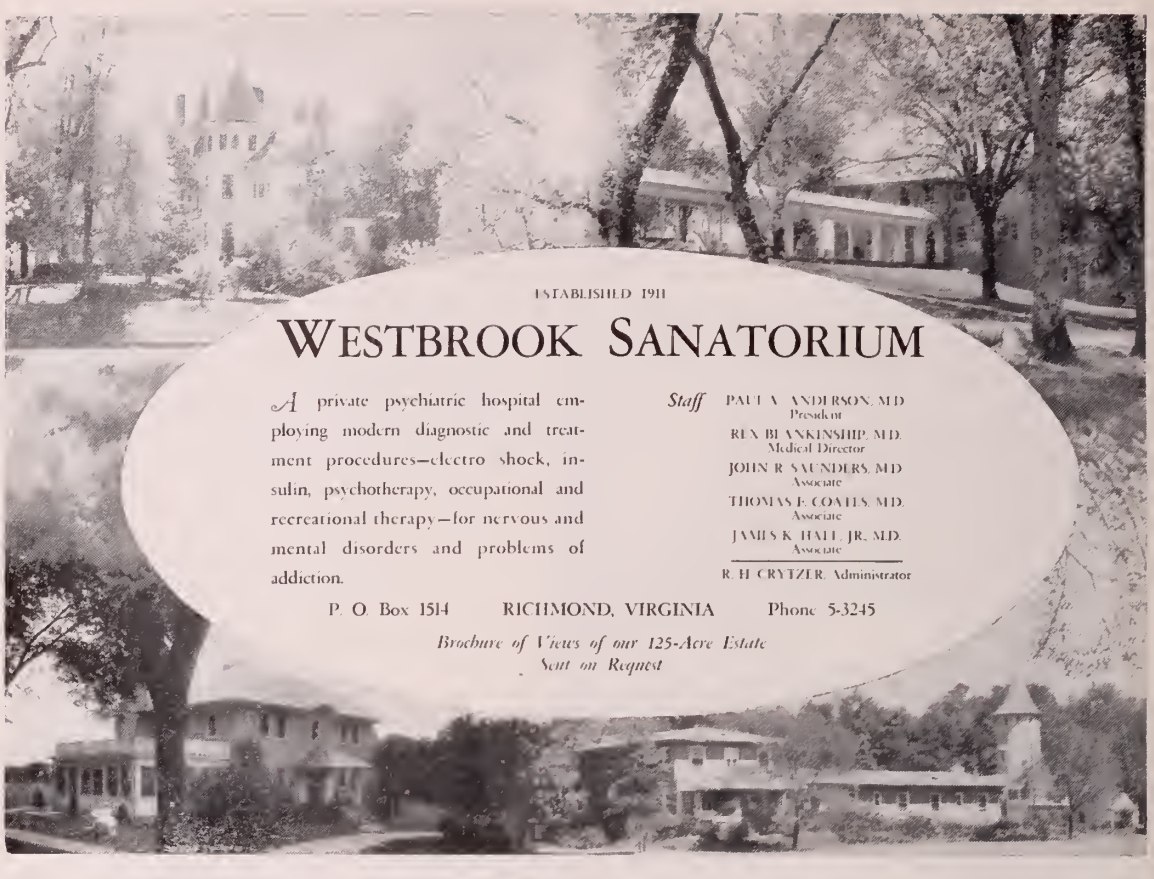
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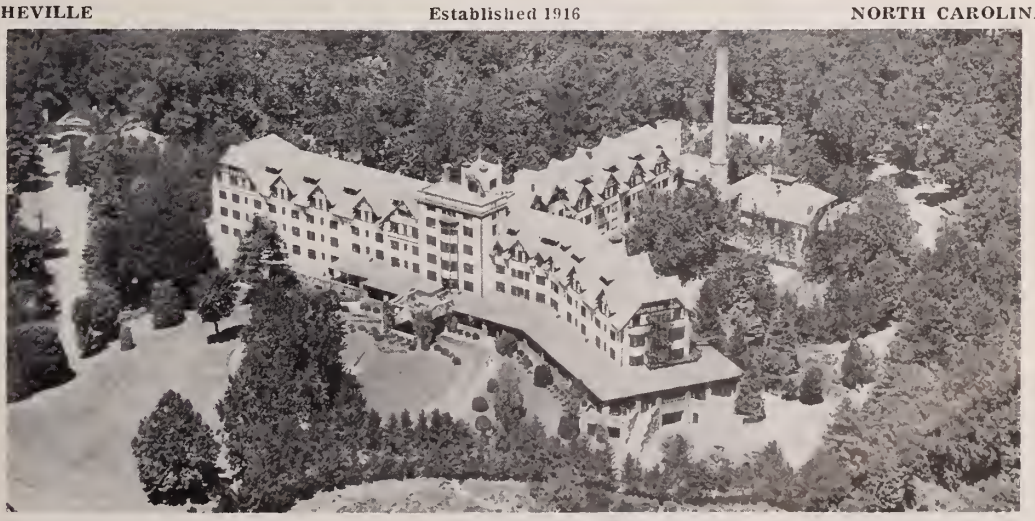
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ical Society	David W. Goddard, Daytona Bch.	W. Dotson Wells, Fort Lauderdale	" " " "
—			
Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Miami, June 9, '56
d Banks, Association	Louis E. Pohlman, Orlando	Mrs. Estelle Lieberman, W. P. Bch.	Pensacola, May '56
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Shield of Florida, Inc.	Russell B. Carson, Ft. Lauderdale	John T. Stage, Jacksonville	
er Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	Miami Beach, May 13, '56
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al Society, State	T. A. Price, D.D.S., Miami	W. A. Buhner, D.D.S., Daytona Bch.	Miami Beach, May 28-30 '56
t Association	Victor H. Kugel, Miami Beach	Edwin P. Preston, Miami	
ital Association	Mr. Pat N. Groner, Pensacola	Mr. Steve F. McCrimmon, C. Gbls.	St. Petersburg, Dec. 8-9, '55
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cal Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
e Anesthetists, Fla. Assn.	Miss Dorothy Jackson, C. Gables	Mrs. Lulla F. Bryan, Miami	St. Petersburg, Dec. 6-8, '55
s Association, State	Martha Wolfe R.N., Coral Gables	Agnes Anderson, R.N., Orlando	
naceutical Assoc., State	Miss Frances Walpole, Sarasota	Mr. R. Q. Richards, Ft. Myers	Clearwater, May 20-23, '56
c Health Association	Mr. J. A. Mulrennan, Jacksonville	Mr. Fred B. Ragland, Jacksonville	
eau Society	Harold W. Johnston, Orlando	Howard M. DuBose, Lakeland	
rculosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mr. Ernest L. Abel, W. Palm Beach	Jacksonville, Apr. 12-14, '56
an's Auxiliary	Mrs. Samuel Lombardo, J'sonville	Mrs. Leffie M. Carlton Jr., Tampa	Miami Beach, May 13-16, '56
n Medical Association	Elmer Hess, Erie, Pa.	Geo. F. Lull, Chicago	Chicago, June 11-15, '56
A. Clinical Session	Elmer Hess, Erie, Pa.	Geo. F. Lull, Chicago	
n Medical Association	Robt. L. Sanders, Memphis, Tenn.	Mr. V. O. Foster, Birmingham	
a Medical Association	F. L. Chenault, Decatur	Douglas L. Cannon, Montgomery	Birmingham, Apr. 19-21, '56
, Medical Assn. of	H. Dawson Allen Jr., Milledgeville	David Henry Poer, Atlanta	Atlanta, May 13-16, '56
ospital Conference	Mr. D. O. McClusky Jr. Tuscaloosa, Ala.	Mr. Pat Groner, Pensacola	Miami Beach, Apr. 18-20, '56
stern Allergy Assn.	Ben Miller, Columbia, S. C.	Kath. B. MacInnis, Columbia, S.C.	Charlotte, N. C., Oct. 5-6, '56
stern, Am. Urological Assn.	Sidney Smith, Raleigh, N. C.	Robert F. Sharp, New Orleans	Hollywood, Mar. 25-29, '56
stern Surgical Congress	Donald S. Daniel, Richmond	B. T. Beasley, Atlanta	Richmond, Mar. 12-15, '56
ast Clinical Society	Walter C. Payne Sr., Pensacola	Barkley Beidleman, Pensacola	

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SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Total Members
Alachua	Edwin H. Andrews, Gainesville	Henry S. Blank, Gainesville	2nd Tues.	55
***Bradford, Gilchrist, Union**				
Bay	William F. Humphreys Jr., Panama City	Roderick C. Webb, Panama City	1st Tues.	28
Brevard	Lee Rogers Jr., Cocoa	Charles E. Russell, Cocoa	2nd Tues.	38
Broward	Ernest E. Serrano, Hollywood	Alfred E. Cronkite, Fort Lauderdale	4th Tues.	123
Columbia	Robert B. Harkness, Lake City	Thomas H. Bates, Lake City	1st Mon.	11
***Baker**				
Dade	L. Washington Dowlen, Miami	Robert F. Dickey, Miami	1st Tues	738
DeSoto-Hardee-Highlands-Glades	Gordon H. McSwain, Arcadia	Harold S. Agnew, Arcadia	1st Tues.	28
Duval	Raymond H. King, Jacksonville	Eugene M. Frame, Jacksonville	1st Tues.	299
***Clay**				
Escambia	George W. Morse, Pensacola	Paul F. Baranco, Pensacola	2nd Tues.	107
***Santa Rosa**				
Franklin-Gulf	Warren T. Weathington, Apalachicola	Joseph P. Hendrix, Port St. Joe	Last Wed.	6
Hillsborough	Frank S. Adamo, Tampa	Julien C. Pate Jr., Tampa	1st Tues.	193
Indian River	Kip G. Kelso, Vero Beach	Vernon L. Fromang, Vero Beach	2nd Tues.	9
Jackson-Calhoun	Henry I. Langston, Marianna	Francis M. Watson, Marianna	Quarterly	17
Lake	Louis R. Bowen, Eustis	J. Basil Hall, Tavares	1st Wed.	29
***Sumter**				
Lee-Charlotte-Collier-Hendry	Baker Whisnant, Fort Myers	James L. Bradley, Fort Myers	3rd Mon.	38
Leon-Gadsden-Liberty-Wakulla-Jefferson	William L. Hunter, Monticello	Odis G. Kendrick Jr., Tallahassee	Quarterly	67
Madison	A. Franklin Harrison, Madison	Wallace E. Winter, Madison		8
Manatee	Marjorie L. Warner, Bradenton	Harvey C. Pauley Jr., Bradenton	2nd Tues.	31
Marion	William H. Turnley, Ocala	Bertrand F. Drake, Dunnellon	3rd Tues.	31
***Levy**				
Monroe	Ralph Herz, Key West	William R. Ploss, Key West	1st Thurs.	15
Nassau	David G. Humphreys, Fernandina Beach	John W. McClane, Fernandina Beach	Last Fri.	11
Orange	Don C. Robertson, Orlando	Walter A. Derrick, Orlando	3rd Wed.	191
***Osceola**				
Palm Beach	Edwin W. Brown, West Palm Beach	James R. Anderson, West Palm Beach	4th Mon.	148
Pasco-Hernando-Citrus	Harry G. Brownlee, Zephyrhills	W. Wardlaw Jones, Dade City	2nd Thurs	17
Pinellas	Clyde O. Anderson, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	226
Polk	Samuel J. Clark, Lakeland	Marion W. Hester, Lakeland	2nd Wed.	102
Putnam	Grover C. Collins, Palatka	Alfred P. Peretti, Palatka	2nd Tues.	10
St. Johns	George C. Hopkins, St. Augustine	Reuben J. Plant Jr., St. Augustine	3rd Tues.	21
St. Lucie-Okeechobee-Martin	Henry E. Branca, Fort Pierce	Adrian M. Sample, Fort Pierce	3rd Thurs.	25
Sarasota	Melvin M. Simmons, Sarasota	Andrew J. Jesacher, Sarasota	2nd Tues.	58
Seminole	John M. Morgan, Sanford	Terry Bird, Sanford	2nd Tues.	20
Suwannee	William P. Blackmon, Jasper	Hiram B. Curry, Jasper	1st Sat.	12
***Hamilton, Lafayette**				
Taylor	John H. Parker Jr., Perry	Ralph J. Greene, Perry	Last Fri.	5
***Dixie**				
Volusia	Robert L. Miller, Daytona Beach	Achille A. Monaco, Daytona Beach	2nd Tues.	83
***Flagler**				
Walton-Okaloosa	Richard H. Lee, Crestview	Frederic E. Caldwell, Fort Walton Beach	3rd Tues	20
Washington-Holmes	L. H. Paul, Bonifay	Bayllye W. Dalton, Chipley		5

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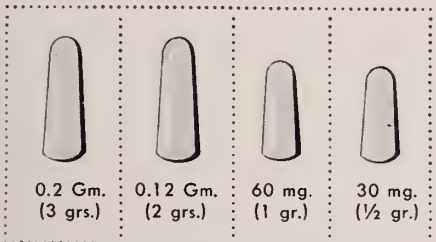
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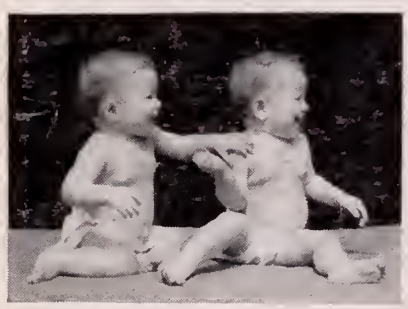


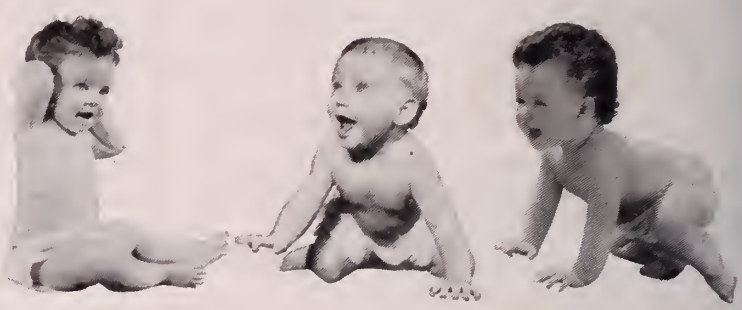
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(1) Jeans, P. C., in A. M. A. Handbook of Nutrition, ed. 2, Philadelphia, Blakiston, 1951, pp. 275-278.

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The Journal
OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XLII JANUARY, 1956 No. 7

Eighty-Second Annual Meeting
Miami Beach, May 13-16, 1956

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Chlorpromazine and Rauwolfia Serpentina
J. M. Bordeleau

Ear, Nose and Throat Problems in Aged
Abraham R. Hollender and Louis G. Lytton

Mirror of The Eye
William J. Gibson

Follow-Up on Poliomyelitis
Robert M. Thorner, B.S.

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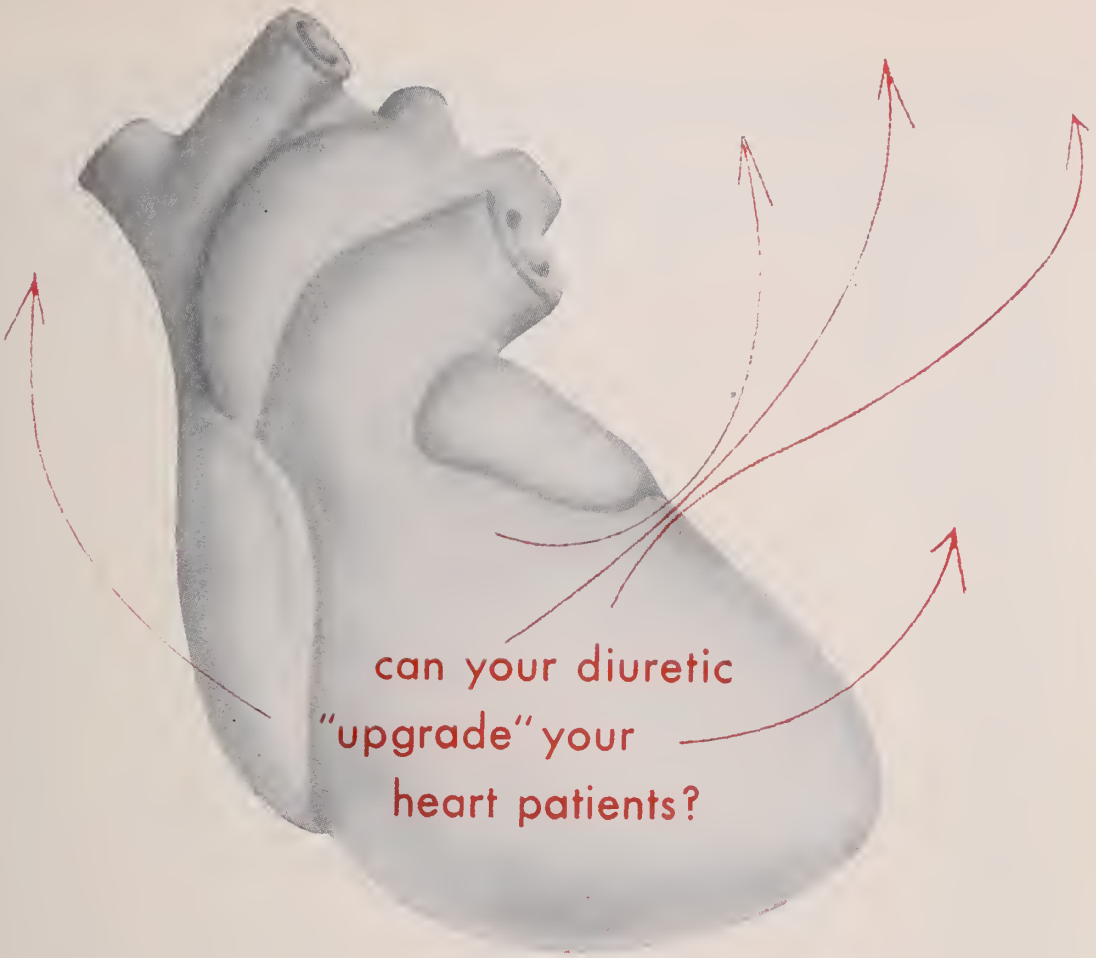
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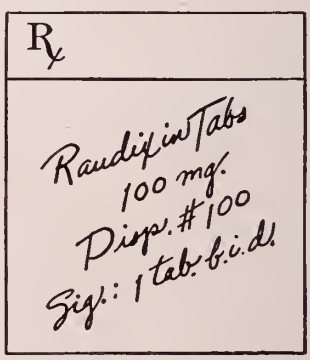
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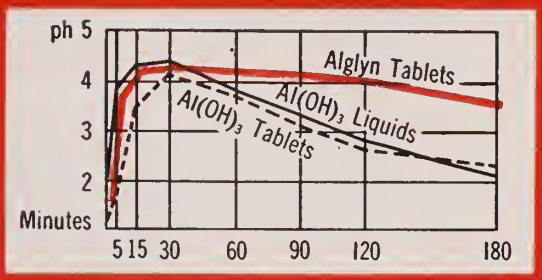


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1. N.N.R., 1956.
2. Hammarlund, E.R. and Rising, L.W.: J. Am. Pharm. Assoc., Scientific Edition, 38:.586, 1949.
3. Rossett, N.E. and Rice, M.L. Jr.: Gastroenterology, 26:.490, 1954.

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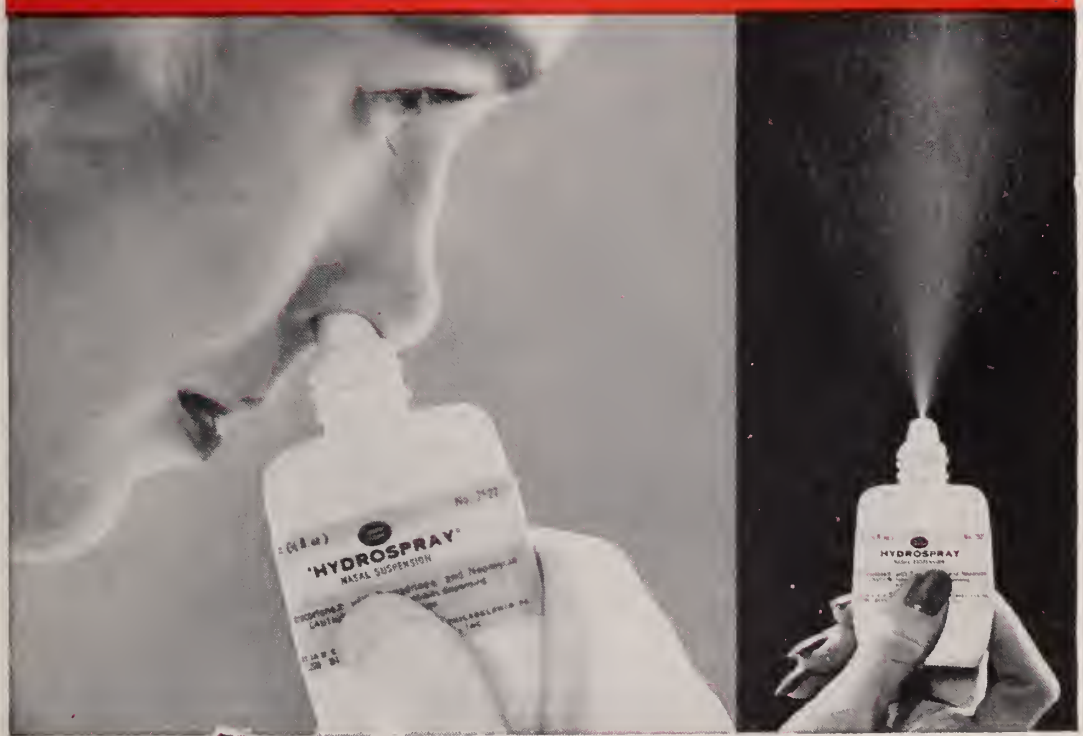
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1. Howell, T.H.; Harth, J.A.P. and Dietrich, M.: Practitioner *173*:172.

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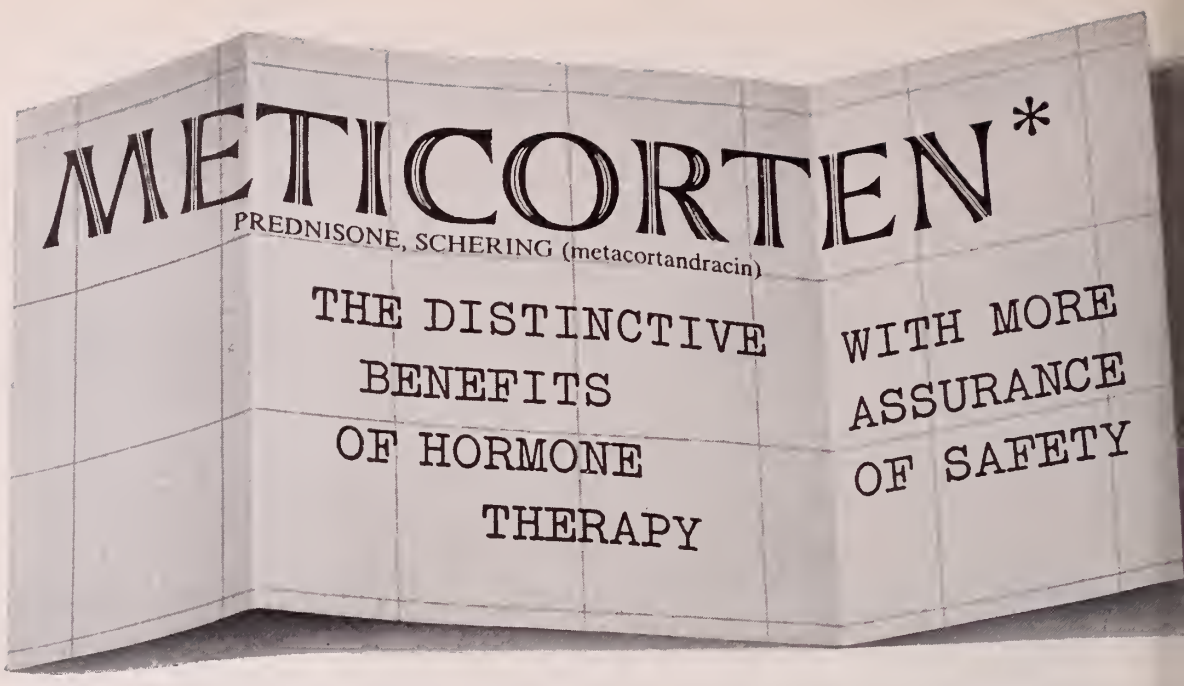
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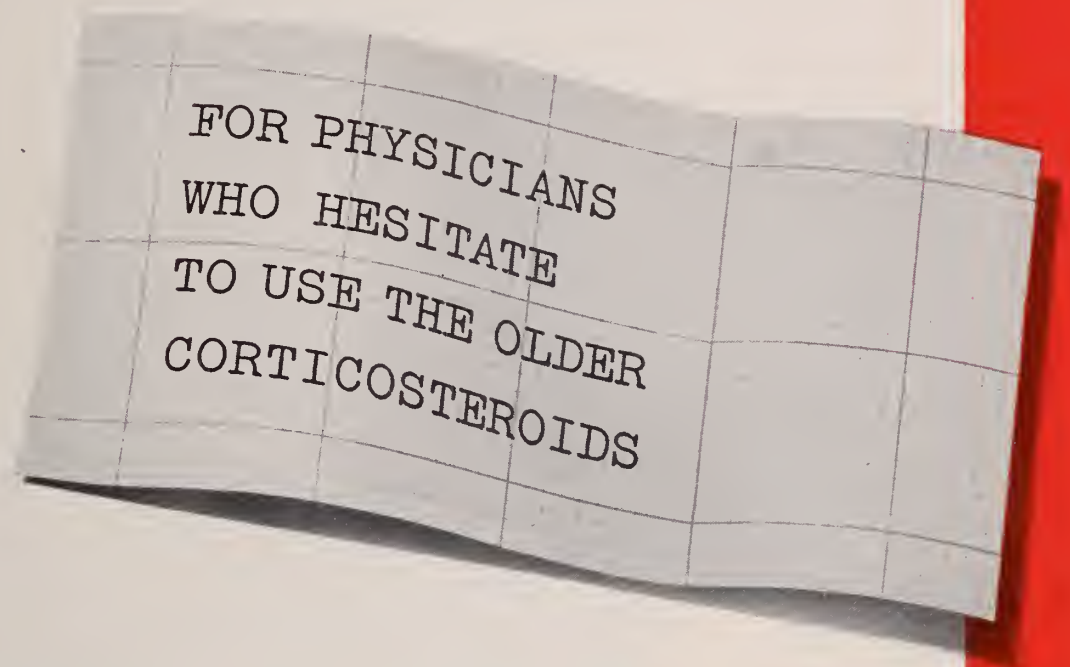
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Clinical Evaluation of Chlorpromazine and Rauwolfia Serpentina in the Psychiatric Department of a General Hospital

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During the last three years, psychiatrists have been gratified with two new therapeutic agents which have been found most useful. The purpose of this work is not to prove that chlorpromazine and rauwolfia have a place in the treatment of psychiatric patients, but to try to find, by a retrospective study, more specific indications and more effective dosages.

Chlorpromazine (Thorazine or Largactil) is a phenothiazine derivative that is structurally related to the antihistaminic Phenergan and to the antiparkinsonian agent Parsidol. It was discovered in France and was first studied because of its potentiating action when given with anesthetics, analgesics, narcotics or sedatives. Laborit,[1] a French surgeon, used chlorpromazine and other drugs in combination with surface cooling of the body to produce artificial hibernation. Soon after, it was found that artificial hibernation could control manic patients;[2] then Delay, Deniker and Harl[3] began using chlorpromazine solely in psychiatric reactions, and since then extensive literature has been written on this subject.

The drug was first used in America by Canadian psychiatrists[4] in 1953 and soon after in the United States, where it is sold under the name of Thorazine. In the Department of Psychiatry at the Duval Medical Center, Thorazine has been used sporadically since the beginning of 1954 and in an increasing number of cases since July 1954.

In October 1954, an enthusiastic report by Noce, Williams and Rapaport[5] encouraged the staff to use reserpine in psychiatric treatment. Reserpine is a pure alkaloid extract of Rauwolfia serpentina, which has been widely used during the past year for the treatment of hypertension. In some cases, we have given Raudixin, a total root extract of this plant. Because of the short clinical trial with reserpine and Raudixin, the impressions given in this study are, of course, preliminary. For this work, we have reviewed the charts of all patients admitted during the period covering July 1954 through February 1955. During this period we had a total of 327 admissions, representing some 303 patients; the readmissions of some patients will explain the discrepancies found in certain findings. Of this group, 173 (52.8 per cent) patients have received chlorpromazine and 49 (14.9 per cent) have received reserpine or Raudixin. Figure 1 shows the continuous increase in the way we have employed these two drugs.

This work is retrospective, and had not been planned prior to the time we began to prescribe these drugs. We are aware of the many deficiencies in the study; nevertheless, we think that such a review may help us evaluate properly the clinical use of these drugs.

Pharmacologic Effects

Chlorpromazine has a weak antihistaminic effect, a moderate parasympatholytic action and a pronounced sympatholytic action. It will lower the blood pressure in most human subjects, but this action is reversible, and the blood pressure

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Read before the staff of the Duval Medical Center, Jacksonville, May 17, 1955.

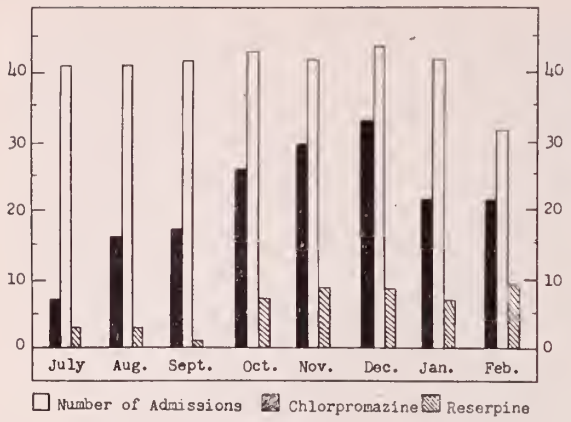


Fig. 1.— Use of chlorpromazine and reserpine in treating patients admitted during the period covering July 1954 through February 1955.

has a tendency to come back to normal after treatment has continued for some time.

The main action of interest in psychiatry is that it produces a depression of the central nervous system, being effective on the motor, autonomic and affective functions. The site of action is not completely known at this time, but there are some indications that it is mediated at the diencephalic level through the reticular system;[6] this depression is not accompanied by clouding of consciousness nor reduction of important intellectual functions. Lehman[7] reported that the reaction time and test performance based on the functions of memory and learning are not impaired with chlorpromazine, while the same functions tend to show pronounced impairments with barbiturates. Even though it is possible to observe some drowsiness, it does not produce the depth of sleep obtained with some other sedatives.

Chlorpromazine also depresses the heat regulation and inhibits the emetic chemoreceptor trigger zone.

The action of reserpine also is interesting. A minor degree of depression of the higher cortical centers is obtained. The tranquilizing effect of this drug was first noted on animals. The result of this drug was to produce a state of quietude and sedation, and the sedation was different from that obtained with other barbiturates.[8] The sleep induced by reserpine is light, and it is easy to arouse the subject. Apparently reserpine has no analgesic effect. We got the impression that the hypnotic effect is greater with reserpine than with chlorpromazine, and the patients receiving this drug are more tempted to stay in bed than those receiving chlorpromazine. Even though we do not know the exact site of reserpine's action on the central nervous system, we may assume that it is on a higher level, probably because of depression of the hypothalamus. Reserpine does not give the typical changes observed on the electroencephalogram tracing when we give barbiturates.

Reserpine in most of the cases gives a pronounced miosis, but the pupillary reaction to light is maintained. It decreases the respiratory rate by increasing the depth of the respiration. It can increase the intestinal tone and the motility, resulting in diarrhea in some cases.

The hypotensive effect is more pronounced than with chlorpromazine, and the fall in blood pressure is consistent. This action, having a considerable interest for internal medicine, has been widely studied and cannot be included in this study. Reserpine also gives bradycardia and hypothermia.

Clinical Evaluation

Many difficulties have been encountered during this work when trying to visualize the clinical action of these two drugs. In some conditions, the action was evident; in others the action was much more subtle. Evaluation of the various aspects of mental illnesses will always be a challenge to psychiatrists. The department in which this study was conducted makes the work more difficult by the fact that it is mostly an observation ward and a center for early and short treatment. A large percentage of our patients are psychotic: many are under commitment, and the course of hospitalization prior to transfer to the state hospital is subjected to many variable factors. A number of these patients were private and after discharge were not seen at this hospital for follow-up. For these reasons, we have been concerned mostly with the results obtained with the drugs during the period of hospitalization.

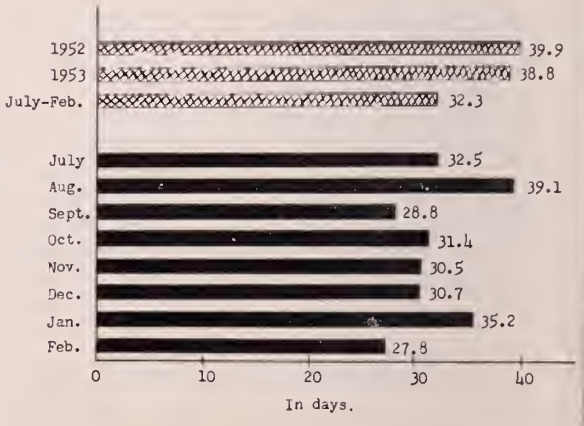


Fig. 2. — Average duration of hospitalization: general group.

Duration of Hospitalization. — Kinross-Wright[9] observed the fact that the use of chlorpromazine accelerates the turnover in a psychiatric department. We have observed a minor decrease in the duration of hospitalization during this period. The increase noted in January can be explained (fig. 2) by the fact that 33.2 per cent, compared to the usual 5 to 15 per cent, of the admissions during this month were for cases of chronic brain syndrome, and disposition of these cases is often difficult and time-consuming. The figure also reveals a slight decrease in the general turnover based on the eight month period covering July through February, as compared with the average length of hospitalization of the general group in 1952 and 1953.

Reduction of Electroconvulsive Therapy. — The use of chlorpromazine and reserpine has reduced considerably the need for electroconvulsive therapy. In practically all of the cases of psychomotor excitement, contrary to what we had to do before, we have been able to control the patients with one or the other of these two drugs. Nevertheless, these drugs will not take the place of this form of treatment in psychiatry, and we have found electroconvulsive therapy necessary in most cases of schizophrenia, for example. This point will be discussed later on. In other psychotic reactions, the association of the drugs with electroconvulsive therapy has been more effective. The relative increase of electroconvulsive therapy during February could be explained by the fact that our rate of admission of schizophrenic patients was higher during that month, the percentage of admission of schizophrenics being 34.3 per cent compared with an average of 25.1 per cent. We think that the reduction observed during November, December and January is a significant observation (fig. 3).

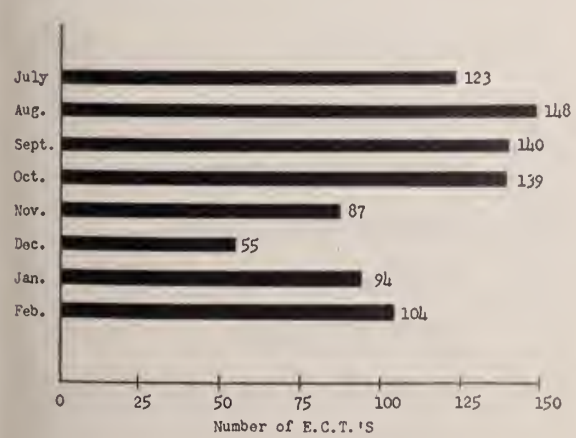


Fig. 3. — Use of electroconvulsive therapy.

In some chronic patients receiving weekly electroconvulsive therapy as a control measure, we have been able to decrease the need for electroconvulsive therapy, and one patient is now well controlled with a monthly treatment as an outpatient.

Symptomatic Treatment of Psychomotor Excitement. — Chlorpromazine, and also reserpine, are of great value in the control of nearly all states of psychomotor excitement. Ninety-six (29.3 per cent) of our patients received chlorpromazine in various types of excitement: catatonic excitement, psychomotor equivalents, agitated depression, delirium of all types, hysterical behavior, acute anxiety attacks, and toxic reactions. It was stressed at the beginning of this work that the sedation given by chlorpromazine has a special quality, giving a motor relaxation but only a minor depression of the higher nervous functions. Ten to 20 minutes after an injection of chlorpromazine, the patient usually falls asleep. It is easy to arouse the patient, and on no occasion will he give the impression of having a "hangover." In some cases it may be necessary to repeat the injection after one hour, and usually the sedative effect will last for four to eight hours. In few cases have we felt it necessary to add barbiturates to potentiate the action of chlorpromazine, which at the time is a most helpful aid in all kinds of psychiatric emergencies and has been widely used in the emergency room.

Reserpine has a similar action, but it is our impression that this effect is not as rapid as with chlorpromazine. It is possible that the effect of reserpine is longer lasting, and that this drug possesses a cumulative power which makes it useful when needed over a long period of time. Our experience with reserpine in psychomotor excitement has been limited, and we do not want to decide at this time if it is more or less helpful than chlorpromazine.

Therapeutic Effects of Chlorpromazine and Reserpine. — The increase in the speed of the turnover, the reduction of electroconvulsive therapy, and even the action on almost all types of psychomotor excitement would have been enough to make a place for these drugs in psychiatric therapy. The fact that they seem to have a therapeutic effect in some forms of mental illnesses makes them more valuable.

We will consider the results obtained in the various forms of mental illnesses, which, for the necessities of this work, have been grouped under the following heads.

Table 1. — Manic Reactions

	Number of Patients	Duration of Hospitalization (in days)	Much Improved	Improved	Controlled	Unchanged
General Group	20	36.7	3 (15%)	10 (50%)	4 (20%)	3 (15%)
Chlorpromazine only	7	31.8	2 (28.5%)	3 (42.8%)	1 (14.2%)	1 (14.2%)
Chlorpromazine and electroconvulsive therapy	7	27.8	1 (14.2%)	3 (42.8%)	2 (28.5%)	1 (14.2%)
Chlorpromazine and reserpine	1	48				
Chlorpromazine, reserpine, and electroconvulsive therapy	3	71.3		3 (50%)	2 (33.3%)	1 (16.6%)
Electroconvulsive therapy only	2	37.5				

MANIC REACTIONS. — This group includes 20 patients, 18 of them having a manic-depressive psychosis during the manic phase. The other 2 patients suffered from a chronic brain syndrome during a manic episode.

It is well known that the manic phase of a manic-depressive reaction will end eventually. The patients in this state nevertheless present many problems due to the nature of their illness. They may become exhausted, they may be aggressive or destructive, and usually they cause a serious disturbance on the ward. Our aim is to reduce the length of such an episode and to prevent a recurrence as much as we can.

The figures obtained in this group (fig. 4 and table 1) show that the length of hospitalization of 4 patients who had been admitted 10 times previously was an average of 44.3 days. These 4 patients this time have an average of 40.5 days. We will use these 10 admissions with 44.3 days as a reference group since they were admitted at a time when neither drug was available, and when they were admitted, they were treated with barbiturates and electroconvulsive therapy.

Seven patients received chlorpromazine alone. They have an average length of hospitalization of 31.8 days. In this group, 1 patient was experiencing her sixth admission, and during her previous admissions she was given each time from 2 to 22 electroconvulsive therapies; every time she was treated, she required a more prolonged course of electroconvulsive therapy. During this admission, in August 1954, she received 100 mg. of chlorpromazine for four days and 200 mg. for 32 days. After 18 days of treatment she was much improved, but stayed in the hospital for observation and treatment for another 18 days. After eight months she is still well and is efficient at her work.

Seven patients received chlorpromazine associated with electroconvulsive therapy, and with this association we have noticed a further reduction to 27.8 days in the length of hospitalization. Even with this reduction, we prefer to begin therapy only with chlorpromazine and we wait to make a decision concerning the need for electroconvulsive therapy. Another important fact is that we are giving now much larger doses than at the beginning, and some patients have received as much as 2,000 mg. daily.

Only 1 patient received reserpine as the initial

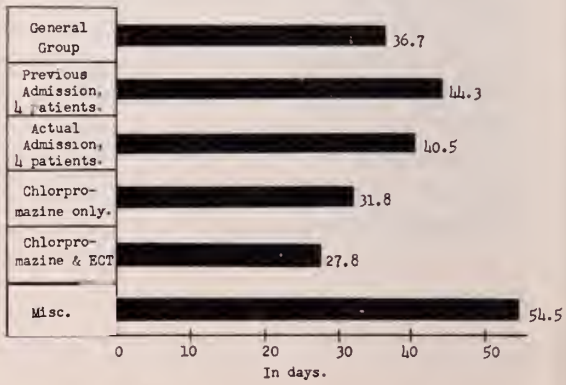


Fig. 4. — Manic reactions.

treatment during a manic episode; he received this drug for two weeks with a dosage varying from 2 to 12 mg. daily by mouth and parenterally. His mental state became worse, and we changed to chlorpromazine with rapid improvement of the condition.

The 3 patients who received chlorpromazine, reserpine and electroconvulsive therapy represent the more severe cases of mania or those having some mental deterioration. They are included in the series for comparison and for the statistical needs, but cannot help in the evaluation of the action of these drugs. In these cases one form of treatment was followed by the other or was at some time associated.

Schizophrenic Reactions. — A clinical evaluation of the results obtained in the schizophrenic group (table 2) is difficult to make because of the wide variation in treatment required. Another difficulty arose when we tried to determine the degree of improvement obtained. For this study a secondary classification, "much improved," is given. We have not felt justified in using the word "recovered" as it has been used in some other reports; nevertheless, the patients classified as "much improved" were completely free of symptoms and could be considered as socially recovered. A major portion of the patients classified as "improved" could be discharged to their families, and some of the "controlled" patients were able to go back into society when the familial conditions were good enough; most of the "unimproved" patients were transferred to the State Hospital or a Veterans Administration psychiatric department. The patients who received no treatment other than Thorazine briefly for immediate control of psychomotor excitement have a proportion of 89 per cent of unimprovement. Most of these represented chronic cases admitted to wait for transfer to another institution.

The group which received only chlorpromazine showed slightly more improvement than the group receiving the drug in association or before electroconvulsive therapy. During the last two months we have tried to give a period of trial with either one of the two drugs before administering electroconvulsive therapy.

Results obtained with reserpine appear poor in this series since almost all the patients receiving it were in a chronic state of schizophrenia. In 2 patients having a well systematized delu-

Table 2. — Clinical Evaluation of Results Obtained in Schizophrenic Group

	Much Improved		Improved		Controlled		Unimproved		Total
	No.	%	No.	%	No.	%	No.	%	
No treatment*			1	5.5	1	5.5	16	89	18
Electroconvulsive therapy only*	3	12	8	32	7	28	7	28	25
Electroconvulsive therapy and insulin coma*					1				1
Insulin coma	2								2
Chlorpromazine only	2	18.2	1	9	6	54.5	2	18.2	11
Chlorpromazine and electroconvulsive therapy			5	50	5	50			10
Reserpine only					5	83.3	1	16.7†	6
Reserpine and electroconvulsive therapy			1						1
Chlorpromazine and reserpine					1	33.3	2	66.6	3
Chlorpromazine and reserpine and electroconvulsive therapy			1	20	2	40	2	40	5
								Total	82

*These patients may have received chlorpromazine or reserpine for psychomotor excitement or for a period shorter than 10 days.

†This patient has received only Raudixin.

sion, but being able to stay in the family for a period of years, we have been surprised that the delusion was somewhat modified and that the patients themselves were complaining that, although they were feeling better, they were unhappy to lose their power of withdrawal. This action of a drug on the autism of schizophrenia is a unique one and may become helpful in the understanding of the dynamics of schizophrenia. A similar action could not be noted so easily with chlorpromazine even though we have suspected it on some occasions.

DEPRESSIVE REACTIONS. — Chlorpromazine and reserpine have only a symptomatic action in most of the cases of depression. They release a part of the tension of the patient, if treated with electroconvulsive therapy, and the patient may feel better than the others not receiving the drugs (table 3).

Table 3. — Clinical Evaluation of Results Obtained in Cases of Depression

	Improved	Unimproved	Total
Electroconvulsive therapy only	13	1	14
Chlorpromazine only	1	1	2
Electroconvulsive therapy and chlorpromazine and/or reserpine	11	1	12
Reserpine only		1	1
Lobotomy	1		1
Other treatment or no treatment	4	2	6
Total			36

One patient receiving reserpine parenterally and by mouth was given an electroshock with Pentothal Sodium and had a respiratory collapse. We know that this drug gives a depression of the respiration; it can also potentiate the action of an anesthetic, and we believe that these two factors were responsible for this accident. Later on, she was given electroconvulsive therapy alone, and no untoward incident occurred. It might be good to avoid the use of Penthothal Sodium when a patient must receive electroconvulsive therapy while on treatment with any one of these drugs.

CHRONIC BRAIN SYNDROME. — The drugs have not changed the course of the illness in cases of chronic brain syndrome, but they have been useful for the tranquilizing effect they produce. They have made the lives of these patients more pleasant by decreasing considerably the need for seclusion, heavy sedation and restraint (table 4).

Table 4. — Clinical Evaluation of Results Obtained in Cases of Chronic Brain Syndrome

	Improved	Unimproved	Total
Chlorpromazine	4	9	13
Reserpine	3	4	7
Chlorpromazine and reserpine	3	4	7
Without chlorpromazine or reserpine	7	9	16
Total	17	26	43

ALCOHOLISM. — Seventy per cent of all our alcoholic patients have received chlorpromazine during the acute episode of intoxication or the transitory psychosis or during a short period of readjustment. As in other types of psychomotor excitement, the drug has been of great help, and patients with acute psychosis as well as patients with toxic psychosis were easier to handle. The length of the period of hospitalization was not shortened in the group receiving chlorpromazine, but the patients were more comfortable during the period of withdrawal.

The factors involved in chronic alcoholism are too complex to be affected by a drug, but the emotional tension and anxiety were decreased. We have found chlorpromazine more useful than barbiturates in releasing these symptoms without any risk of addiction.

Chlorpromazine cannot be the only treatment of acute alcoholism; the other measures are still necessary (vitamins, nutrition, et cetera). Even if the drug is most effective in quieting these patients, the potential risk of cerebral edema is always present, and an appropriate therapy must be given.

OTHER PSYCHIATRIC INDICATIONS. — Chlorpromazine and reserpine have been used in several other psychiatric conditions mostly for their symptomatic effect. In psychoneurosis they have been most useful in decreasing the degree of anxiety. It is nevertheless a symptomatic treatment and must not be an excuse to discard psychotherapy. In many cases, chlorpromazine and reserpine will enable the physician to begin it.

In cases of personality disorders, they possess the same effect to a lesser degree; the danger of addiction is considerably decreased since they do not cause, except with unusually high dosage, the "thrilling" and mysterious action for which all psychopaths are looking. The relaxation induced consists of a sense of well-being which is slow but sure. For that reason, it was of great help during the withdrawal phase of the treatment of drug addiction.

Side Effects

With Chlorpromazine. — Much has been said about the side effects of chlorpromazine. We have not seen any cases of real addiction to the drug, and many patients who have taken the drug for a relatively long period have been given freedom to decrease it. They were always proud of their achievement. In this regard, chlorpromazine possesses the same placebo effect as any other drug and is voluntarily included in the complex patient-doctor interrelationship. It may easily be assumed that some of the results attributed to the drug are, in fact, caused by the influence and personality of the physician.

We have observed during the first two or three days of medication a lowering of the blood pressure. We did not feel justified in keeping the patients in bed for this time but have instructed the nursing staff to supervise patients closely during this period. All the instances of syncope were due to orthostatic hypotension, were short, and no serious effects were derived from them.

One of the most common complications was the muscular pain induced at the site of the injection. It was usually severe enough to discontinue this route of administration; as a rule this complication developed after several days of treatment when the acute episode was subsiding and the oral route could be used.

There were minor gastrointestinal symptoms like constipation and abdominal cramps. In this group of 173 patients, we have not observed a single case of jaundice as has been reported on many occasions[7-11] and by some of our attending psychiatrists in their private practice. When jaundice appears, it is usually after the second week and seldom after one month of treatment. For this reason, we have always been most careful to avoid administration of this drug when liver damage was known or suspected; we have adopted the same attitude when treating alcoholic patients.

We have observed allergic reaction in some cases. Only in two instances was it necessary to discontinue the medication, and in the other cases the patients were given antihistaminic and local treatment of the skin condition.

Two patients with Parkinson's disease have been improved with small dosage of chlorpromazine, but the tremor became worse when the dosage was increased to 200 mg. daily. An extrapyramidal syndrome mostly marked by muscular rigidity in the limbs and sometimes hypersalivation has developed in many patients; 1 patient had a "masklike" face but no tremor. This side effect disappeared soon after cessation of the drug.

Reserpine. — With reserpine, we have found that the hypotensive action was more pronounced and more prolonged than with chlorpromazine; the end result was a considerable increase in the number of syncopal attacks. Since this drug was used mostly during this time for the treatment of patients who were not so hyperactive as the other group, we have given the injection at bedtime, and we did not have to keep these patients in bed. The gastrointestinal effects were also minor: nausea, abdominal spasm and often diarrhea. One good side effect of reserpine was the usual increase in appetite, and most of the patients receiving this drug gained weight during the period of treatment.

The extrapyramidal syndrome was observed more frequently with reserpine than with chlorpromazine. In many patients a cogwheel rigidity and a stiffness of gait developed. Some patients complained of the stiffness, but most of them were not disturbed by the rigidity. In 1 case, there was a considerable increase of saliva, which dropped freely from the mouth. Richman and Tyhurst[12] observed this side effect in 12 out of 19 patients receiving this drug. The same authors observed 2 cases of paradoxic hypertension in their group.

Dosage

Chlorpromazine. — There is a tremendous amount of variation in the way the drug was used. At first we proceeded with caution and kept patients on relatively small dosages. Thereafter we began to give progressively increasing dosage, starting with 50 mg. four times a day and reaching in seven to 14 days, 500 mg. four times a day. We believe that patients having received such dosage were more improved than when the same quantity was given during a longer period of time. Some patients receiving 2,000 mg. daily complained of drowsiness, but in no cases were the side effects more frequent in this group. In fact, the threshold of susceptibility seems to vary from one individual to another; for example, the patients in whom a Parkinson syndrome was developing were not receiving the exceedingly high dosages.

For a tranquilizing effect in patients seen at the outpatient clinic, we have usually given from 10 to 100 mg. four times a day, according to the degree of emotional tension and disturbance.

Chlorpromazine, as stated previously, was widely used in almost every case of psychiatric emergency (except suicidal attempts with barbiturates) and in cases of acute psychomotor excitement. Usually we have given 25 to 50 mg. intramuscularly, and this medication may have been repeated two or three times during a 12 hour period. The injection must be given slowly deep in the gluteal muscle.

We have never administered chlorpromazine by the intravenous route.

RESERPINE. — We did not use reserpine often in cases of psychomotor excitement, but a dose of 5 mg. by intramuscular or intravenous injection has a definite sedative effect, which usually comes later than with the other drug but lasts longer.

In an attempt to obtain a therapeutic effect on psychotic patients, we have given high dosages of reserpine: 5 to 15 mg. intramuscularly with 2 to 4 mg. orally. For the reasons stated, we have given the injection at bedtime.

For our patients in the outpatient clinic, the dosage given to obtain a relaxing and tranquilizing effect has been from 1 to 3 mg. daily in divided doses.

For either drug, we have given the medication from 15 days to several months, and we believe that the medication must be continued for a long time to maintain the improvement.

Comments

In this study, we have considered the action of chlorpromazine and reserpine and the results obtained in a psychiatric department acting primarily as an observation ward and a center for early treatment. A large number of our patients are psychotic, and the average short term hospitalization does not permit us to perform anything other than supportive and superficial psychotherapy. We have received these drugs with much enthusiasm since they are responding to a real need. We have found the action of these drugs (mostly chlorpromazine) most helpful in almost every case of psychomotor excitement of any type. We have appreciated the tranquilizing effect of both drugs (mostly reserpine) in the treatment of chronic anxiety reaction and emotional tension accompanying schizophrenic, depressive, and other psychiatric reactions. In the disturbed patient, they give a relaxation which will permit psychotherapy.

We have observed no curative effect of these drugs, except in cases of mania where the episode was shortened and the clinical recovery was maintained. We believe that in such cases the prompt use of chlorpromazine can prevent the recurrence of an attack.

The side effects we have observed were minor. We are, like other workers, surprised by the fact that chlorpromazine, given in small doses, will have an antiparkinsonian action and that the same drug, with larger doses, will make the parkinsonism worse and in some cases give a transient parkinsonism; this latter action was more frequent with reserpine, but disappeared spontaneously when these drugs were discontinued.

Even if we do not think that chlorpromazine and reserpine are miraculous drugs in the treatment of mental illnesses, they are useful, most of the time, in the symptomatic treatment of these conditions and have opened a new field of investigation which is worth while.

Summary

Chlorpromazine, a phenothiazine derivative, and reserpine, a purified extract of Rauwolfia sepentina, have been given in our department in 52.8 per cent and 14.9 per cent, respectively, of a group of 327 patients admitted during the period covering July 1954 through February 1955. After studying the pharmacic effects of each drug, we have tried to evaluate the clinical effect obtained with these two drugs.

Grateful acknowledgement is made of the professional interest and assistance of Dr. Sullivan G. Bedell, Chief of Staff, Memorial Unit, Duval Medical Center, Jacksonville.

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Ear, Nose and Throat Problems in Older Persons

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There are close to 10 million people in this country over 65 years of age, and, it is predicted, in 1980 there will be 26 million.[1] This increasing number of older persons owe their longer life span to spectacular developments of modern medicine. "If it is important to give the human animal a good start in life," wrote Lawton,[1] "it is just as important to see that he makes a good finish. We should be as much interested in actual fulfillment as in setting the stage for the realization of possibilities."

In his book, Diseases in Old Age, Monroe[2] emphasized in the introduction: "If geriatrics is to become a distinct discipline among the medical arts and sciences, it must develop and constantly accumulate a body of facts and methods comparable to those which make up pediatrics." Though geriatrics as a special field in medicine has made distinctive progress and continues to make even greater progress as time goes on, there still remain gaps to be filled by authentic information. One of these gaps has to do with the more careful consideration of ear, nose and throat problems.

Old age has been classified as physiologic and pathologic. In the former, Lawton[1] pointed out, there is a gradual process of cell atrophy and a relative increase in the supporting tissues of the bodily organs. In the latter, "severe bodily diseases make later life intolerable and exert most depressing mental effects upon the person."

Disabilities of the Ear, Nose and Throat

What has been said applies to all sorts of infirmities and disabilities, those of the ear, nose and throat being no exception. Heatly[3] included in the otologic problems of the aging patient acute and chronic infections; inner ear disturbances in the form of deafness, tinnitus and vertigo; and neoplastic diseases.

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According to Proetz,[4] changes in the character of the respiratory tract due to old age are likely to be less upsetting and disabling than those encountered in some other regions and organs. This author wrote: "They are more likely to cause annoyances and discomforts than real disabilities and rarely have any effect on life expectancy. . . The affections of the nose and throat which can be classified strictly as the concomitants of age are few and result largely from simple atrophies of the mucosa, the glands and the muscles similar to those found elsewhere in the body."

Plan of Study

The present study was undertaken (1) to ascertain the nature of ear, nose and throat problems in older persons one encounters in office practice; (2) to ascertain the problems in aged persons one has to deal with in hospital practice; (3) to learn what sort of disabilities one has to contend with in residents of a home for the aged; and finally, (4) to comment on the prevailing types of ear, nose and throat diseases in advanced age under all circumstances.

Ear, Nose and Throat Problems in Older Persons in Office Practice

In office practice one is consulted frequently by persons with acute or chronic diseases of the ear, nose and throat, but in actual percentage, ear problems exceed those of the other structures. The predominating complaint is that of hardness of hearing. Our statistics closely approximate those of Alexander,[5] who found that the incidence of deafness rose with each successive decade, and between the ages of 65 and 74 years hearing defects were present in 1 of every 14 men and 1 of every 18 women. In men, almost invariably, the deafness was of the nerve or combined type. In women, the hearing was likewise of the nerve type, with approximately 20 per cent of those afflicted giving a history of otosclerosis. From this information, it is clear, as Alexander stated, that deaf-

ness is one of the problems which the lengthening of life has intensified.

Associated with the deafness, in a small percentage of older persons, are the symptoms of vertigo and tinnitus. The triad comprises what has come to be known as Menière's syndrome. Since arteriosclerosis is common in the older age group, it occasionally becomes necessary to differentiate aural vertigo from vertigo caused by cerebrovascular changes. Tinnitus, too, as is well known, is sometimes produced by a hypertensive state. As a consequence, the diagnosis of Menière's syndrome in older persons often presents a definite problem. Unless the attack is of an acute nature, most patients suffering from the syndrome are ambulatory and are satisfactorily managed in office practice.

As concerns nasal and sinus disease, the incidence in our series of cases was not especially high. In approximately 12 per cent of the patients, nasal or sinus operations had been performed. The operation most frequently done was septal resection. Most of the nasal complaints were of the acute type, more or less self-limited conditions like the common cold, or complications of it. Evidence of chronic rhinitis or sinusitis was observed in 20 per cent of the patients, though approximately one fourth of these never knew they had such involvement. Common symptoms included nasal stuffiness, postnasal discharge, headache, hawking or coughing. The sinuses more frequently implicated were the maxillary and the ethmoid.

Nasal allergy was only occasionally diagnosed clinically. Those patients who presented clinical evidence of allergy were usually engaged in occupations conducive to this state. Some had asthma, or a tendency to it. Others had an old history of hay fever dating back to childhood.

In 10 to 15 per cent of the patients, definite atrophic changes, or a pronounced atrophy of the nasal structures was observed. Since many of these persons had had intranasal operations in youth or middle life, it is impossible to state whether the atrophy was a sequence of the earlier surgery or due to natural aging changes.

Few if any patients complained of sore throat, though those who did presented large cryptic tonsils and gave a history of repeated episodes of tonsillitis. It was striking to observe large hypertrophied tonsils even in a small percentage of the patients because early involution of these structures is usually taken for granted. The complaint, tonsillitis, was infrequent. Keleman,[6] in a survey of the palatine tonsil in the aged, noted only 8 cases of acute tonsillitis in 309 patients.

Complete involution of the tonsils, in the light of present knowledge, is considered to be rare, though a steady decline in the size of the tonsils, as age increases, is the usual process. Keleman[6] held that local inflammations, tonsillar and peritonsillar, are infrequent and take the same course as in any other age group. He concluded that around the sixth decade there is a period of high tonsillar activity; regression seems to cease with even a slight possible temporary enlargement. "This means," he observed, "that there is a characteristic period of increased tonsillar activity at the onset of senescence corresponding to the similar period before puberty."

Hoarseness was not an uncommon complaint. The acute type was associated with the common cold. In a few it was attributable to overexertion, fatigue or general debility. In approximately 1 out of 12, chronic hoarseness represented the major problem. Though in older persons, as is well known, chronic hoarseness should always be regarded with suspicion of a serious underlying disease, it did not follow that such a state was always found to exist. Proetz[4] claimed that degeneration of the muscles of the larynx occurs with advancing age, the alteration having an effect on the voice.

Eight out of 100 patients with chronic hoarseness presented benign tumors or granulomas, while 7 presented carcinoma, subsequently confirmed by biopsy. Syphilis was encountered only once and tuberculosis twice in 100 representative cases.

Ear, Nose and Throat Problems in Older Persons in Hospital Practice

In the large majority of instances, hospitalized patients included those originally seen at the office. Rarely were patients seen in the hospital for the first time unless it was for an ear, nose and throat consultation requested by an internist or general practitioner. Of those patients thus seen, the main reason for the consultation was to uncover a focus of infection. In a series of 100 cases, sufficiently representative to permit average conclusions, this attempt was successful in only 5 per cent.

Other problems which had to be dealt with were in patients who required endoscopy or surgical intervention. Endoscopy, that is, either laryngoscopy, bronchoscopy or esophagoscopy, was required in 25 per cent for diagnostic purposes. In 40 per cent, foreign bodies represented the indica-

tion for the procedure. In 35 per cent an indicated operation was the reason for hospitalizing the patients.

Tonsillectomy was infrequently performed in persons past 65 years of age. In 100 consecutive records of adults hospitalized for tonsillectomy, it was noted that only 2 of the patients were over 65 years of age. In fact, only 8 were over 50 years of age. One of us (ARH) had performed a tonsillectomy on a man, aged 75 years, who was in a toxic condition and in whom mental symptoms had developed. The patient made an uneventful recovery from the operation with complete relief from the symptoms. Keleman[6] concluded from his own experience and the apparent lack of reports on operative accidents that there is no reason why the advantages of a tonsillectomy should be denied persons of advanced age. In this connection, it is of interest to note the report of Wilkinson,[7] who stated that in a series of over 11,000 cases of tonsillectomy performed at the Mayo Clinic, 355 patients were between the ages of 60 and 79 years.

One of the more frequently encountered emergency problems in older persons is epistaxis. It may be the first symptom suggesting hypertension. Though venous bleeding is easily controlled, arterial bleeding may require ingenious management on the part of the rhinologist. In severe situations, transfusion may be necessary, and even life-saving. In the area in which we practice, the tourist population includes a high percentage of persons of advanced age. Many of these suffer from hypertension. As a consequence, epistaxis is of frequent incidence. Because the loss of blood appears alarming, persons in whom nasal hemorrhage suddenly develops are promptly transported to the hospital.

Head, nasal or facial injuries also account for hospitalization of older persons. Because head trauma may produce skull fracture, bleeding from the ears frequently calls for otologic consultation. Nasal fractures result from falls, from direct trauma, or from automobile accidents. In a tourist area like ours, these problems become hospital emergencies, though in some instances it is possible to release patients to their home after administering to them.

Ear, Nose and Throat Problems in Residents of a Home for the Aged

In an effort to decide whether older persons boarded in a home provided for them present ear, nose and throat problems of a similar or different type than those encountered in office or hospital practice, a survey was made of 60 persons in the Jewish Home for the Aged of Greater Miami. It should be understood at the outset that the examinations were of a routine nature, no complaints having been registered by any of them. The age extremes were 65 and 90 years.

The examinations revealed the following findings, which in our opinion are significant and merit reporting:

Ears.—External otitis was uncommon, though 15 per cent of the subjects complained of itching ear canals. In only one person was a chronic otorrhea observed. Those who were in apparently good health presented drum pictures usually seen in persons of middle age. In a few, the ear drums appeared scarred. In the large majority retraction was common.

Three persons complained of vertigo and 9 of tinnitus. Twenty-five had a hearing loss ranging from moderate to severe. Four persons wore hearing aids.

Nose and Sinuses.—Deviations of the septum were common. In nearly all persons examined, the septal mucosa was dry, parched and pale. The mucosa of the inferior and middle turbinates presented a similar picture. Though polyps were seen in only 3 persons, polypoid degeneration of the turbinates was common. In only 1 person was breathing obstructed by the presence of large typical polyps.

Approximately 20 per cent of those examined gave a history of sinus disease at some time during their lifetime. None presented evidence of active sinusitis at the time of examination.

Mouth and Pharynx.—Pigmentation of the lips was more or less a uniform finding. More than one fourth of the group presented a definite perleche, and in 6 persons there were increased fat deposits in the buccal mucosa. In 12, pronounced varicosities or tortuosities were seen at the base of the tongue.

Of the entire group, the tonsils were absent in only 3. A significant observation was the absence of atrophy of the faucial tonsils in at least one half of the group. In fact, most of the faucial tonsils appeared hypertrophic. The lingual tonsils showed definite atrophic changes. The nasopharynx contained some lymphoid tissue in at least 20 per cent of the group.

Larynx.—Though there was no typical hoarseness in any of these persons, alterations in the voice were common. In the age group between 75 and 90, a weak, unnatural voice was the rule,

the change being more pronounced as age advanced.

The larynx itself exhibited an atrophic mucosa in all the parts. There was a decided thickening of the vocal cords in 3 persons. The epiglottis appeared flabby in nearly every instance. There was 1 case of contact ulcer. There were no palpable cervical glands in any of the subjects.

General Comment

In this study we undertook to classify our subjects in three distinct categories, more for convenience than for necessity. Advancing age takes its toll of the structures in the head and neck in the same manner that it does of the structures in other parts of the body, with few exceptions. There seems to be no doubt that certain physiologic changes take place with normal aging, but aging seldom proceeds as an entirely normal process. This applies without reservation to the ears, nose and throat, structures lined by tissues which not only must pass through the aging process but must constantly resist disease and the accidents of life. "There is growing evidence," stated Carlson,[8] "that hereditary constitution is also a factor in the life span of specific individuals within the species, irrespective of ignorance, faulty diets, infections and other accidents in the life of the individual. This appears also to be true for the life span of the individual organ or system within the individual." If this reasoning is sound, it may explain in some degree at least why, for example, a structure like the ear deteriorates with partial or complete loss of function.

In our patients, irrespective of categories, a noteworthy observation was atrophy of structure. This is undoubtedly a change that can be attributed correctly to the normal aging process, but, as is well known, it may develop also at any age and be accounted for by disease or be induced by artificial means. Removal of certain structures, like the turbinates in the nose, usually induces an atrophic state. On the other hand, atrophy may result from causes like faulty nutrition, infections and other factors, some of which may be completely obscure.

In our entire series it was of no small interest to note variations in the hearing function of persons of all ages, but especially those who come within the range of this study, that is, between 65 and 90 years. Some persons past the eighth decade possessed keener hearing than those in the lower age group. It is, of course, difficult to explain this variation without obvious cause or reason unless we accept Carlson's view that the degree of retrogression is not predictable on the basis of chronologic age.

Contrary to the persistent belief that, for example, the lymphoid structures invariably atrophy with advancing age, we constantly encountered situations to refute it. Though in many instances the tonsils, adenoids and other lymphoid structures decrease in size as age advances, this is far from being a uniform development. Carlson[8] emphasized that on the whole, both the aging factor as such and the accidents of living appear to deal lightly with the lymphatic system.

Older persons are said to be especially subject to neoplastic disease. Though the incidence of malignant growths is high in persons past 50 years of age, some will take issue with this statement. Obviously, neoplasms represent no process that can be laid to normal aging, and must, therefore, be ascribed to other causes.

In general, it may be said that older persons may contract and suffer from the same types of inflammatory diseases of the upper part of the respiratory tract as commonly afflict younger persons. In the management of these conditions, few if any restrictions need be considered because of the age factor.

Experience has demonstrated that oldsters withstand operations well, irrespective of their nature, and this is especially true of ear, nose and throat operations.

In our survey of boarding home residents, it was noteworthy that despite the existence of pathologic conditions in the upper portion of the respiratory tract, complaints were rare. Most of these older persons suffered from other disabilities, some of a major character, and concern over them overshadowed less serious existing ailments of the ear, nose and throat.

Conclusions

Because ear, nose and throat problems in older persons are of considerable interest in the general study of geriatrics, more information is desirable to enable a clearer understanding of the subject.

The aim of this study was to determine whether any special differences exist in the diseases of older persons encountered in office practice, in hospital practice, and in a home for the aged. Such differences as exist are adequately described.

Our study leads to the conclusion that advancing age takes its toll of ear, nose and throat structures in the same manner as it does of other structures of the body, with few exceptions. But it

should not be assumed, unless proved, that the aging process is responsible for every pathologic process in older people just because the etiology would otherwise remain obscure.

Thewlis[9] appropriately emphasized that thoughtful consideration of the underlying principles of geriatrics will convince physicians that it is a worth while study and that our present attitude toward the aged and their ailments is negative. It behooves otolaryngologists to keep abreast of the implications this statement may have in their special field.

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Discussion

Dr. Mozart Lischkoff, Pensacola: The span of life is continually increasing, and it is anticipated that there will be 25 million people in the United States over 65 years of age within 20 years, at which time the life expectancy will be greatly increased.

It is timely that this subject is brought before us, and I congratulate the authors for presenting it in such a lucid manner.

Aging in involuntary, and it is important to treat otorhinolaryngologic conditions in the aged and to recognize the fact that they are, as a rule, no distinct entity physiologically and pathologically. The geriatric problem is important, and that is our problem.

The incidence of nasosinus disease is not especially high in the 60 to 85 year age group because they have had better medical care than the corresponding group had one or more generations ago, and the neglected septal deviations and hypertrophic tonsils do not subject them to frequent respiratory infection. Hoarseness in this group is most important and should be investigated thoroughly. A careful examination of the larynx is necessary in every case.

The acute dysphagias usually occur concomitant with infections of the upper part of the respiratory tract and in many cases result from muscular atony or paralysis, but about 8 per cent are said to result from benign tumors or granulomas while almost 10 per cent are malignant. Syphilitic laryngitis is comparatively rare while tuberculous laryngitis occurs less frequently than formerly. One does not see the syphilitic ulcers in the larynx that were fairly common, especially in the Negro, a generation ago.

Most of the geriatric patients suffer from disabilities that overshadow their ear, nose, and throat ailments so that these complaints are considered minor unless we include deafness and vertigo. In this group most of them appear to be on a vascular basis and are not primarily classified as presenting otolaryngologic problems.

The correction of disfiguring wrinkles and sagging skin to alleviate disfigurement is increasing as the span of life tends to increase the importance of rhinoplasty for the enhancement of the industrial, sociologic, and psychologic rehabilitation of the growing senescent population. These and other plastic procedures will soon be transferred from the category of luxury to necessity.

We should be grateful to Dr. Hollender and Dr. Lytton for bringing us this subject, and I appreciate the opportunity to discuss it.

Dr. Hollender, concluding: Although disturbed function may manifest itself in the organs of the upper part of the respiratory tract at any age, it often becomes especially noteworthy in persons of advanced years. Our study revealed only a meager literature dealing with the geriatric aspects of otolaryngology. This single fact increased our own interest and led us to investigate the subject from the points of view reported on.

Though geriatrics is making rapid strides, research is constantly exposing new and unexplored relationships in the various specialties. If otolaryngology is to keep abreast, it behooves us to recognize that ear, nose and throat problems in persons of advancing years require special consideration and study.

The report of delegates from the Florida Medical Association to the American Medical Association's Clinical Session held November 29-December 2 at Boston is published in this issue of The Journal beginning on page 577.

The Mirror of the Eye

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The ancients considered the eyes the mirror of the soul. Today physicians know the eyes reflect changes in remote areas of the body. In no other part of the body can changes in the arteries and veins be so readily visualized as in the ocular fundus. No single method of physical examination is as important as opthalmoscopy. One may consider fundal changes in disease as variations on a single theme, namely, blood vessel alterations.

Diabetes

Diabetes is perhaps one of the most important problems to engage the attention of physicians. In this disease the earliest changes in the eye are usually minute red hemorrhagic spots, in reality microaneurysms, seen alone or in association with small sharply defined spots of exudate.[1] They appear as a rule near the macula or between it and the disk (fig. 1). In the course of time these areas increase and may coalesce (fig. 2a) to make large yellowish masses of exudate. With these may be seen capillary size or larger hemorrhages (fig. 2b). After several years, new vessels appear near the disk. Tiny at first, they become larger and more numerous until eventually groups of vessels with connective tissue extensions appear, marking the development of retinitis proliferans (fig. 3).



Fig. 1. — Diabetes, left eye, showing small capillary hemorrhages (microaneurysms), occasional areas of round hard exudate between the disk and macula.



Fig. 2. — (a) Showing coalescence of areas of exudate to make large yellowish masses.



Fig. 2. — (b) Showing exudate and capillary size and larger hemorrhages in diabetic retinopathy.

Occasionally, large hemorrhages form between the retina and the vitreous (fig. 4). Retinopathy is most frequently observed in diabetes of mild degree, but may be present in any grade, and is not dependent upon the lack of effective control measures. Thus, paradoxically, one may see the internist telling the patient that he is doing well, and the opthalmologist crying for more effective control measures. Bedell[2] stated: "The most important opthalmologic dictum is that the retinopathy is in direct relation to the duration of the diabetes regardless of the age of the patient when it starts. The prognosis is increasingly grave after diabetes has been present for twenty years."

Read before the St. Johns County Medical Society, St. Augustine, December 1954.



Fig. 3. — Showing new blood vessel formation in retinitis proliferans as shown by connective tissue extensions from the optic disk into the vitreous.

Hypertension

Even when high blood pressure has been present for several years, the retinal vessels appear normal in about one third of the cases of hypertension, according to Sorsby[3]. Bedell[1] was of the opinion that the majority of hypertensive patients show no deviation from normal in this respect.

Normally, walls of blood vessels are invisible except near the disk, and a retinal artery crosses a vein without indenting it or slowing down the blood flow. When, however, the degenerative process results in thickening and stiffening of the arterial wall, the vein is compressed and may be displaced slightly (fig. 4). The most widely known classification of the changes of hypertension is that of Keith, Wagener and Barker.[4] According to their scheme, Class I reveals slight narrowing with increased light reflex (fig. 5), Class II shows segmental and diffuse narrowing with irregularity of the arterioles and compression of the arteriovenous crossings. Class III shows these changes plus retinopathy as shown by hemorrhage and exudate. Class IV shows all of the changes mentioned plus papilledema.



Fig. 4. — Showing compression and displacement of the vein with thickening and stiffening of the arterial wall.

In hypertension, the light reflex is interfered with until it resembles a bright copper wire. As time passes the vessel wall further thickens until the reflex resembles that of a silver wire (fig. 6).

With alterations in their walls the vessels become incontinent, and hemorrhage and edema from leakage of capillaries and veins occur. The hemorrhage, exudates and edema may come and go even as the degeneration progresses (fig. 7).

The decision as to whether surgical intervention is indicated is dependent in its final sense upon how much associated renal damage has occurred. Class IV (fig. 8) is almost always associated with greater or less renal damage and consequently has a poor prognosis.



Fig. 5. — First stage of arterial hypertension, Keith-Wagener-Barker Class I, showing slight narrowing and increase of the light reflex of arterial walls.



Fig. 6. — Showing copper wire and silver wire arterioles (also associated with choroidol sclerosis in this photograph).

Renal retinopathy may in its final stages appear exactly the same as that seen in fulminating hypertension. Characteristically, renal retinopathy shows changes similar to those of the Keith-Wagener-Barker Class III, with edema predominant, and a star figure may form at the



Fig. 7.— Keith-Wagener-Barker Class IV; the entire retina and nerve are involved in a process characterized by edema, hemorrhage and choke of the optic nerve head.



Fig. 8.— Leukemic retinopathy, to show vascular engorgement, diffuse hemorrhage, cotton wool patches and retinal edema. Roth spots are not evident in this specimen.

macula with soft white cotton wool patches (fibrin exudation) seen scattered about the retina.

Toxemia of Pregnancy

In toxemia of pregnancy the first symptoms suggesting retinal pathologic change may be spells of transitory blindness or merely spells of blurred vision. The changes again are vascular and a reflection of generalized disease.

The early symptoms are usually from arterial spasm and are of vital significance. Rarely an observer is privileged to see an artery go into spasm and orgasmically relax while under observation. When the spells of blurred vision increase in frequency or duration and/or retinopathy is present in the form of retinal edema and exudate, the uterus should be emptied to prevent permanent hypertension, nephritis, optic nerve damage, or even total blindness.

If the toxemia is not relieved, the retina becomes edematous, hemorrhages occur, the blood vessels narrow, and even detachment of the retina may ensue from subretinal exudate. If the patient survives, any degree of visual damage may result.

Blood Dyscrasia

Leukemia may be chosen as an example of fundal changes taking place in blood dyscrasis. Retinopathy occurs in about two thirds of all cases of leukemia according to Sorsby.[3] This consists of vascular engorgement associated with hemorrhages, cotton wool exudate patches and edema. The picture again is of vascular incontinence. In the acute leukemias the so-called Roth spots may be observed; they are irregular, rounded, hemorrhagic areas with a nodular white center. In severe anemia, and exsanguination, fundal changes are seen as hemorrhages and transitory retinal edema.

Subacute bacterial endocarditis and septicemia show these manifestations including the Roth spots, but the lesions appear rapidly and in showers, and then slowly subside.

Summary

In summary, one may look on the retina as the mirror of the vascular tree of the entire body. In it are reflected the changes that occur in diseases of areas remote from the eye, notably, diabetes, hypertension, toxemia of pregnancy, and blood dyscrasias.

Grateful acknowledgment is made to the Department of Photography, New York Eye and Ear Infirmary, New York City, for permission to use the accompanying illustrations.

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A Follow-Up Study of Reported Cases of Poliomyelitis, Florida, 1954

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In 1947, an article appeared in the World Health Organization's Epidemiological and Vital Statistics Report bearing the ominous title, "The Incoming Tide of Poliomyelitis." The author, a W.H.O. Epidemiological Consultant named Knud Stowman, attributed the development of epidemic poliomyelitis to the mutation of the relatively rare Heine-Medin disease, and intimated that a continued increase in incidence might be anticipated.

Sufficient experience has been accumulated since 1947 to enable the Florida State Board of Health to take both a backward and forward look from that date. As indicated in figure 1, the tide of poliomyelitis is apparently on the rise in Florida.

Some of the increment in reported case rates has undoubtedly resulted from increased diagnosis and reporting of nonparalytic cases. It has long been known that for every clinically recognizable and paralytic case, there are many more infections of varying degrees of less severity, and recognition and reporting of these cases in increasing proportions may be taking place. A rise in case rates of the magnitude indicated in figure 1, however, cannot be attributed to increased reporting alone, and poliomyelitis must be recognized as a disease of increasing incidence.

As indicated in figure 1, the year 1954 was by far the year of the highest attack rate of the disease on record in this state. A total of 1,832 reports of cases with dates of onset in 1954 was received. This number of cases is nearly two and one-half times the number reported in the previous year, and Florida ranked fifth in the nation in state polio case rates.

Every year as the incidence of polio begins to rise in the spring, public interest in and fear of the disease begin to rise. Health officers at the county and state level receive many inquiries for information, requests for advice and requests for allocations of gamma globulin.

The routine reports of cases received and tabulated at the State Board of Health provide some of the information required, and aid in decisions concerning the allocation of gamma globulin. The morbidity reporting system thus serves adequately the prime purpose for which morbidity reporting was originally instituted; it promptly alerts the medical profession to the danger, pinpoints the danger area, and enables health authorities to initiate appropriate control actions within the limits of the present abilities and knowledge of the disease.

A secondary and probably equally important function of a morbidity reporting system is to gather detailed statistical data which may be used for a variety of purposes — for epidemiologic studies, for actuarial purposes in determining insurance rates, for assessing the magnitude of the disease as a public health, welfare and rehabilitation problem, and for basic data in planning future control measures.

For these purposes the routine system of reporting poliomyelitis falls far short of the desired goal, for while the nonparalytic case or the case exhibiting temporary paralysis may play an equally important part with the permanently paralytic case in maintaining a reservoir and spreading the infection, for a final assessment of the

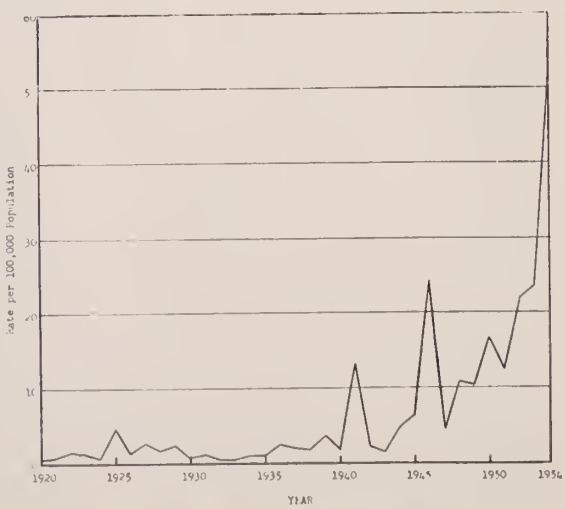


Fig. 1.— Reported cases of poliomyelitis per 100,000 population, Florida, 1920-1954.

Statistician, Florida State Board of Health.
Read before the Florida Health Officers' Society, Tenth Annual Meeting, St. Petersburg, April 4, 1955.

Table 1. — Reported Cases of Poliomyelitis by County with Results of Follow-Up and Case and Death Rates, Florida, 1954

COUNTY	Reported Cases and Results of Follow-up							Rate per 100,000 Population		
	Total Reports	Paralytic	Death	Non Paralytic	Not Polio	Cannot Locate	Not Followed up	Total Polio	Paralytic	Death
STATE	1,832	849	58	672	34	32	187	51.6	24.4	1.7
Alachua	11	7	0	3	0	1	0	17.9	11.4	—
Bay	54	20	3	29	0	2	0	103.2	38.2	5.7
Bradford	1	1	0	0	0	0	0	8.7	8.7	—
Brevard	13	0	1	0	0	0	12	33.6	—	—
Broward	99	32	3	54	6	4	0	69.5	23.9	2.2
Calhoun	3	2	0	1	0	0	0	39.1	26.1	—
Charlotte	1	1	0	0	0	0	0	19.5	19.5	—
Clay	9	5	0	3	0	1	0	48.3	26.8	—
Collier	6	3	0	3	0	0	0	62.9	31.5	—
Columbia	2	0	1	1	0	0	0	10.0	—	5.0
Dade	281	157	9	104	7	4	0	40.9	23.4	1.3
DeSoto	4	2	0	1	0	1	0	43.1	21.6	—
Duval	133	55	9	63	2	4	0	34.7	14.5	2.4
Escambia	37	20	3	12	0	2	0	24.9	13.5	2.0
Franklin	2	0	1	3	0	0	0	36.5	—	18.3
Gadsden	16	12	1	21	1	0	0	45.8	36.6	3.1
Glades	2	1	0	1	0	0	0	76.5	38.2	—
Gulf	4	4	0	0	0	0	0	44.2	44.2	—
Hamilton	2	2	0	0	0	0	0	21.9	21.9	—
Hardee	2	0	0	2	0	0	0	17.5	—	—
Hendry	4	3	0	1	0	0	0	60.7	45.5	—
Hernando	1	1	0	0	0	0	0	13.0	13.0	—
Highlands	1	1	0	0	0	0	0	6.6	6.6	—
Hillsborough	118	57	6	48	3	4	0	37.3	18.5	1.9
Holmes	11	10	1	0	0	0	0	84.6	76.9	7.7
Indian River	3	0	0	3	0	0	0	20.7	—	—
Jackson	17	10	1	4	2	0	0	42.3	28.3	2.8
Jefferson	12	0	1	11	0	0	0	119.4	—	9.9
Lake	3	1	0	2	0	0	0	6.9	2.3	—
Lee	16	9	2	5	0	0	0	54.1	30.4	6.8
Leon	450	193	0	80	2	0	175	783.8	337.6	—
Liberty	6	5	0	0	1	0	0	189.0	189.0	—
Madison	5	3	1	1	0	0	0	34.8	20.9	7.0
Manatee	17	14	0	1	0	2	0	40.2	33.1	—
Marion	2	2	0	0	0	0	0	4.6	4.6	—
Martin	4	0	1	3	0	0	0	42.8	10.7	—
Monroe	39	22	0	17	0	0	0	85.7	48.4	—
Nassau	6	4	0	1	1	0	0	34.1	28.3	—
Okaloosa	14	5	0	9	0	0	0	37.0	13.2	—
Okeechobee	1	1	0	0	0	0	0	24.7	24.7	—
Orange	69	18	5	44	1	1	0	41.4	11.0	3.0
Osceola	3	1	0	2	0	0	0	23.4	7.8	7.8
Palm Beach	63	33	3	27	0	0	0	40.8	21.4	1.9
Pasco	8	5	0	2	1	0	0	29.2	20.8	—
Pinellas	81	41	2	38	0	0	0	39.4	20.0	1.0
Polk	71	29	1	33	2	0	0	46.1	19.4	0.7
Putnam	5	2	0	3	0	0	0	18.8	7.5	—
St. Johns	3	3	0	0	0	0	0	10.5	10.5	—
St. Lucie	14	3	0	8	3	0	0	43.6	11.9	—
Santa Rosa	5	2	1	2	0	0	0	23.4	9.4	4.7
Sarasota	22	14	0	8	0	6	0	61.6	39.2	—
Seminole	7	2	0	4	1	0	0	18.5	6.2	—
Suwannee	4	3	0	1	0	0	0	24.2	18.2	—
Taylor	5	1	0	4	0	0	0	38.5	7.7	—
Volusia	35	14	1	19	1	0	0	39.0	16.0	1.1
Wakulla	7	1	1	5	0	0	0	138.8	19.8	19.8
Walton	13	9	0	4	0	0	0	86.4	59.8	—
Washington	5	3	0	2	0	0	0	42.9	25.7	—

damage done it is necessary to differentiate between permanently paralytic cases and nonparalytic and temporarily paralytic cases. This is especially true in epidemic years when the ratio of reported nonparalytic cases to reported paralytic cases generally increases.

Physicians were requested some years ago to distinguish between paralytic and nonparalytic cases when sending in case report cards. It is frequently necessary, however, to allow for the passage of some time before a positive determination of permanent paralysis can be made. The objective of the establishment of an accurate diagnosis of permanent paralysis is therefore in direct conflict with the objective of prompt reporting of cases.

To overcome this basic difficulty and to begin the collection of a body of statistical material for analysis, the Bureau of Preventable Disease and the Bureau of Vital Statistics of the State Board of Health instituted a follow-up study in 1954.

County health units throughout Florida were asked to follow up reported cases after a lapse of at least 30 days, and to report to the Bureau of Preventable Disease the final diagnosis of the cases. Participation was on a voluntary basis, and the cooperation received was excellent. This paper presents a summary and analysis of the data gathered in 1954.

Table 1 shows a summary of reported cases and their final outcome by county, and rates for paralytic and nonparalytic cases.* Counties not reporting polio cases were omitted from the table.

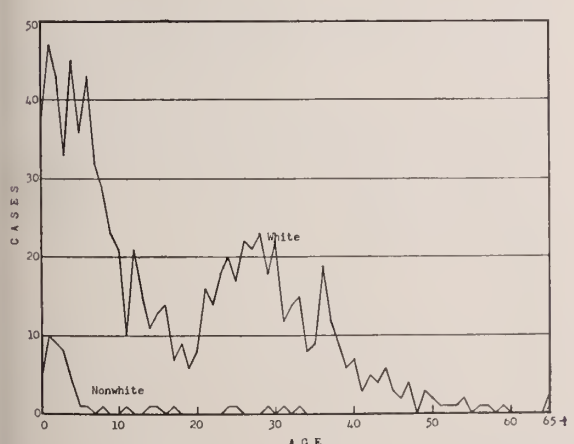


Fig. 2. — Paralytic poliomyelitis by age and race, Florida, 1954.

*Paralytic cases for this report are defined as those showing some degree of permanent residual paralysis 30 days or more after the onset; other cases have been classified as nonparalytic.

Column 1 is the total of the number of case reports received. This figure includes some cases which were allocated to diseases other than polio when a final diagnosis was determined. These

Table 2. — Paralytic Poliomyelitis Cases and Deaths by Age, Race and Sex, Florida, 1954

AGE	RACE AND SEX				
	TOTAL	WHITE		NONWHITE	
		Male	Female	Male	Female
All Ages	907	374	485	25	23
Under 1	43	19	19	3	2
1 Yr.	57	26	21	6	4
2 Yrs.	52	26	17	6	3
3 Yrs.	41	18	15	4	4
4 Yrs.	49	26	19	2	2
5 Yrs.	37	19	17	0	1
6 Yrs.	44	21	22	1	0
7 Yrs.	32	18	14	0	0
8 Yrs.	30	20	9	0	1
9 Yrs.	23	14	9	0	0
10 Yrs.	21	16	5	0	0
11 Yrs.	11	5	5	1	0
12 Yrs.	21	13	8	0	0
13 Yrs.	15	5	10	0	0
14 Yrs.	12	6	5	0	1
15 Yrs.	14	8	5	0	1
16 Yrs.	14	6	8	0	0
17 Yrs.	8	0	7	1	0
18 Yrs.	9	4	5	0	0
19 Yrs.	6	3	3	0	0
20 Yrs.	8	0	8	0	0
21 Yrs.	16	3	13	0	0
22 Yrs.	14	3	11	0	0
23 Yrs.	18	5	13	0	0
24 Yrs.	21	4	16	1	0
25 Yrs.	18	8	9	0	1
26 Yrs.	22	5	17	0	0
27 Yrs.	21	9	12	0	0
28 Yrs.	23	7	16	0	0
29 Yrs.	19	6	12	0	1
30 Yrs.	22	9	13	0	0
31 Yrs.	13	4	8	0	1
32 Yrs.	14	4	10	0	0
33 Yrs.	16	8	7	0	1
34 Yrs.	8	1	7	0	0
35 Yrs.	9	3	6	0	0
36 Yrs.	19	5	14	0	0
37 Yrs.	12	3	9	0	0
38 Yrs.	9	2	7	0	0
39 Yrs.	6	1	5	0	0
40 Yrs.	7	3	4	0	0
41 Yrs.	3	0	3	0	0
42 Yrs.	5	2	3	0	0
43 Yrs.	4	2	2	0	0
44 Yrs.	6	1	5	0	0
45 Yrs.	3	1	2	0	0
46 Yrs.	2	0	2	0	0
47 Yrs.	4	0	4	0	0
49 Yrs.	3	0	3	0	0
50 Yrs.	2	0	2	0	0
51 Yrs.	1	0	1	0	0
52 Yrs.	1	0	1	0	0
53 Yrs.	1	0	1	0	0
54 Yrs.	2	1	1	0	0
56 Yrs.	1	0	1	0	0
57 Yrs.	1	0	1	0	0
59 Yrs.	1	0	1	0	0
65 Yrs.	2	1	1	0	0
Unknown	11	0	11	0	0

cases must be deducted to arrive at the total number of polio cases. Thus of the 1,832 cases reported for the state, 34 were found to be cases in which the disease was one other than polio, and the net figure is 1,798 cases of polio reported.

The 34 cases in which the disease was not polio were for the most part diseases characterized by symptoms similar to polio and difficult to differentiate on clinical evidence alone. Some of the final determinations were made after death and included meningitis and brain tumors.

The 849 paralytic cases and 58 deaths represent 50 per cent of the total polio cases. If the cases not followed up and the cases in which the patient could not be located are deducted from the total, the paralytic cases and deaths represent 57 per cent of the cases successfully followed up.

Case rates for total polio, paralytic polio and polio deaths are also presented in table 1.

Some perspective may be placed upon this highly emotionally charged disease by a comparison of the case rate with that of other diseases. In 1954 the new case rate for tuberculosis was 70.7 per 100,000 population. This was one of the lowest tuberculosis yearly case rates on record, and is to be compared with the highest polio rate on record of 51.6 cases per 100,000. The syphilis case rate of 198.0 per 100,000 and the accidental death rate of 60.5 per 100,000 also exceed the poliomyelitis case rate. Certainly tuberculosis, syphilis and accidents can be as crippling as polio, but they do not create the public fear that polio does.

Information concerning the incidence of paralytic poliomyelitis by age, race and sex was also tabulated. White females with a rate of 34.3 paralytic cases per 100,000 population had the highest rate. This compares with the white male rate of 27.1 per 100,000. The excess of the female rate over the male is chiefly the result of the unusually high incidence of the disease among white women in Leon County.

The white rates greatly exceeded the nonwhite rates, which were 7.5 for males and 6.5 for females. Similar racial differences have been noted in past years. Seventy-seven per cent of the paralytic cases among nonwhites were cases in children under six years of age.

In view of the probable development of an immunizing vaccine for polio in the near future, the age distribtuion of cases is of prime interest. The age distribution of paralytic cases is presented in figure 2 and table 2.

The peak incidence in 1954 was in the early years from birth through age six. After that the number of paralytic cases falls sharply, reaching a low at age 19, rising again in the ages from 20 to 35, and diminishing rapidly after that age. The rise in the number of cases in the age group of 20 to 30 is only partly explained by the incidence of the disease among adults in Leon County.

Present plans for use of the Salk vaccine call for the immunization of first and second graders. This group has been chosen partly on the basis of incidence figures and partly because the organization of the immunization program can be accomplished rapidly through the schools.

As a long range objective, immunization at the earliest practicable age is indicated by these incidence figures. If sufficient vaccine is eventually made available, immunization of the entire population may be considered a valid objective.

The Salk vaccine offers hope that polio may eventually become as rare a disease as smallpox, diphtheria and tetanus. Complete eradication cannot be anticipated for no disease has ever been completely eradicated by immunization.

A continuation of the reporting and follow-up of poliomyelitis cases will enable us to judge the effectiveness of any control measures which may be instituted in Florida, and the continued participation of county health units in the study will be appreciated.

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82nd Annual Meeting
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ABSTRACTS

Correlation of the Type of Labor with the Roentgen Findings. By J. Maxey Dell, Jr., M.D. South. M. J. 48:604-609 (June) 1955.

In this paper the author presents his experience in 1,000 obstetric cases in which the Ball method of cephalopelvimetry was used. A study of this type may offer the obstetrician objective aid in predicting the type of labor anticipated and may give him early indications for cesarean section. In this study the methods and results are described in some detail. The types of labor or section are classified as (1) normal labor, (2) difficult labor, (3) nonelective section, and (4) elective section.

The conclusions are that it would be foolish to suppose anyone will be able to say that a patient will or will not have a difficult labor in the middle or questionable group, but one can safely say that in a large group there will be no difficulty from disproportion between the head and the bony maternal pelvis. Also, in a smaller group one can predict fairly accurately that difficulty will occur sufficiently often to warrant a cesarean section and in another small group that a trial of labor is indicated. The factors of age, strength of the maternal musculature, type of pelvis and sacrum, correction factor for the head and the length of time between roentgen examination and delivery must all be evaluated in the decision as to the conduct of labor.

Blood Extract Therapy in the Intractable Arthritic. By J. A. Mease, Jr., M.D. Medical Times (Oct.) 1954.

A simple method of therapy with blood extract, employed in a series of 3,000 cases, is here presented. The method of preparation of the blood extract, the method of therapy, the method of adjunct therapy, and clinical experiences with this large series over a five year period are described. In 50 per cent of these cases of intractable arthritis pronounced improvement was reported, in 40 per cent appreciable benefit, and in 10 per cent failure. It was noted that the benefit seemed greater in cases of osteoarthritis than in other uncomplicated cases. No serious complications were encountered in the series. The view is expressed that further intensive chemical analyses will eventually improve the extract and the specificity of this procedure.

Succinic Dehydrogenase and Endogenous Reductase Activity in the Rabbit Ovary in Pregnancy. By Alvan G. Foraker, M.D., Sam Wesley Denham, M.D., and Dorothy D. Mitchell, A.B. J. Obst. & Gynaec. Brit. Emp. 62:447-451 (June) 1955.

Localization of sites of succinic dehydrogenase and endogenous reductase activity in the ovary of the rabbit during pregnancy is the subject of this report. At this time the ovary is subject to morphologic and physiologic change of considerable degree. Since it is both the initiator and the recipient of hormonal stimulation, it should afford in pregnancy an excellent testing ground for the postulation that the distribution of sites of succinic dehydrogenase activity may correlate with certain types of cell function, such as hormone production. Such demonstration should also be a noteworthy contribution to the knowledge of the growth, histology, histochemistry and function of the ovary.

The results of this study of sites of dehydrogenase and alkaline phosphatase activity, lipid and glycogen in midgestational rabbit ovaries showed:

(1) Pronounced evidence of dehydrogenase and alkaline phosphatase activity and lipid in lutein cells.

(2) Pronounced evidence of dehydrogenase activity and lipid, and less evidence of alkaline phosphatase activity in stromal cells.

(3) Lesser degrees of evidence of enzyme activity in certain other cell components.

(4) Glycogen and other periodic acid-Schiff positive substances, and lipid in conventionally described distribution patterns.

Possible correlation of sites of enzyme activity with sites of hormone production is reviewed.

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Social Security — Big Issue in '56

Every physician who is conscious of his duties as a citizen should now be taking an active interest in a timely issue which the American Medical Association considers of great importance — not only to the medical profession but to all of the American people.

That issue is HR 7225, a bill passed by the United States House of Representatives last summer near the end of the Congressional session. This bill, known as the Social Security Amendments of 1955, was first rushed through the House Ways and Means Committee without public hearings. Then it was passed in the House, by a vote of 372 to 31, under a suspension of the rules which barred amendments and limited debate to 40 minutes. The Senate Finance Committee, however, refused to take hasty action on a bill of such major importance. After hearing the many serious questions raised by Mrs. Hobby, then Secretary of the Department of Health, Education, and Welfare, the Committee decided to hold extensive public hearings during the second session of the 84th Congress.

Just what is this legislation that appears to be so politically attractive to individuals with an eye on the 1956 elections? Why was the House majority leadership so determined to avoid open hearings and normal debate? Let's take a brief look at the main provisions of the bill.

This is the legislation which would lower the Social Security retirement age for women from 65 to 62; extend monthly benefits for permanently and totally disabled children beyond the age of 18; expand compulsory social security coverage to all self-employed professional groups except physicians, and raise social security taxes over and above the increases already scheduled for the next 20 years. Those provisions alone demand careful study of their effects on the philosophy, scope and financial stability of our social security system.

The most controversial section of the bill, however, is the one which would make permanently and totally disabled persons eligible to receive their social security retirement benefits at age 50 instead of 65. It is this section which is of particular concern to the medical profession. It is of far greater concern than the question of voluntary or compulsory coverage of physicians under the social security system. That is a sepa-

rate issue which is not discussed in this editorial. The plan for a national system of permanent and total disability benefits has far more serious implications for medicine and the nation.

It raises questions such as these: Is there any real need for a federal program? What are the facts on permanent and total disability? Will this not duplicate or overlap existing programs of assistance and rehabilitation? What effect will cash handouts have on a patient's incentive to be rehabilitated? Will this not extend federal control over physicians? — and, finally — How will this affect the future of medical practice? Will this lead, step by step, to the lowering and eventual elimination of the age 50 eligibility requirement; then, cash benefits for the dependents of those who are permanently and totally disabled; then, a temporary disability benefits program; then, cash benefits or direct government payments for hospital or medical costs, and then, ultimately, a full-fledged system of government health insurance?

These are but a few of the many grave questions which already have been raised concerning this legislation. As physicians, we must be concerned over the medical aspects of the problem. As citizens, we also must be concerned over the trends and implications in the never-ending expansion of our social security system. The minority report of the House Ways and Means Committee expressed it this way:

"We do not believe that our committee has discharged its obligation to either the Congress or to the American people by its brief and closed-door consideration of this vital legislation. We have sought to point out the grave social and economic implications of the bill. We have dwelt at some length with the staggering ultimate costs of this developing program, because we do not believe that either the Congress or the public has any conception of its magnitude."

Our social security system now has reached the point where any further changes may have a profound influence on the nation's economic, social and political future. The time has come to face up to the question of just what social security should accomplish and just where it should stop. The American Medical Association strongly urges that the social security issue be taken out of the arena of vote-catching politics; that there be an objective, thorough study of social security in all its present and future aspects, and that the facts and realities emerging from such a study be used as the basis for a sound national decision on this vital issue. It especially protests precipitate action on the complex question of disability without thorough investigation of alternative mechanisms.

That position is a reasonable, responsible policy that deserves the moral and intellectual support of every physician.

The Medical Legislative Load

With the Congress convening for the second session of the 84th Congress, the rapidity with which the medical legislative load is increasing at the national level is of particular interest to all physicians. When the medical profession was catapulted into the legislative field on the socialized medicine issue a few years ago, it acquitted itself in the grand manner, the while hoping for surcease, even recourse to its former lethargy regarding national legislative matters. One battle won, however, does not win a war. As physicians throughout the country have watched the legislative trend since that time, they have come to appreciate more and more the necessity for remaining legislative-conscious from the medical standpoint.

The magnitude of the profession's current legislative load is emphasized by recent statistics. This load is now twice as heavy as it was during the preceding two years. Of sufficient importance to be reported in the AMA Washington Letter were 403 medical bills among a total of 11,914 measures introduced in the first half of the present Congress, beginning in January 1955. They were only four less than the 407 such bills among 16,470 bills introduced in both sessions of the 83rd Congress, which extended from January 1953 to the end of December 1954.

Of these 403 medical bills introduced in the first session of the 84th Congress, 49 had hearings during that session. Eleven of the 49 were reported favorably by the committee which considered them. Seven of these 11 were passed by the House in which they were introduced. Five of the seven were passed by both Houses and signed into law by the President. The American Medical Association supported four of these five.

With a record number of bills of medical interest introduced in that session and but few enacted into law, the second session now getting under way in this election year promises to hold lively interest for physicians. What the Congress

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(Continued from page 571)

did not do in the first session it may do in this session. Among the many bills remaining in the Washington hopper are some to which the medical profession is firmly opposed.

Adjournment last August left two medical bills of particular importance at the halfway mark in the Congress. The Democratic-sponsored national compulsory disability insurance plan, discussed in the preceding editorial, passed the House and is pending in the Senate Finance Committee. The Hill-Bridges $90 million grants bill for construction of research facilities passed the Senate and is pending in the House Interstate Committee. Also, still before committees but with hearings completed are the Jenkins-Keogh tax deferment bills and federal aid to medical education. Other medical bills among the many facing the Congress now that it is back in session are: aid to nursing education, dependent medical care, contributory health insurance for federal workers, mortgage guarantees for health facility construction, reinsurance of voluntary health plans, military medical scholarships, and practical nurse training.

As legislative proposals pertaining to medicine continue to pyramid in the Congress, every physician needs to be both wary and wise as well as ever vigilant if he is to do his part in protecting the best interests of the public and the profession in health matters. The American Medical Association and its component societies are constantly at work for him, endeavoring to keep him abreast of developments, for he must be informed and likewise forthright in his stand on legislation.

Health bills, President Eisenhower reminded a press conference some time ago, should be handled as soon as the Congress reconvenes. It is now in session, Doctor. Are its members from your home district fully apprised of your views on the measures vital to medicine?

Safest While at Work

Work appears to be less hazardous than it would seem. In fact, it seems to be safer to work than not to if one would minimize the risk of accident. Statistics show that employed persons sustain more accidents when not at work than when they are working, according to a study of male industrial insurance by the Metropolitan Life Insurance Company.

Accidents at home, on the streets and highways, and during recreation account for nearly 70 per cent of the accidental deaths and more than half of the disabling accidents. The automobile accident toll was discussed editorially in the June, 1955, Journal.

In some occupations all or nearly all of the fatal injuries were sustained by workers outside of working hours. Workers in cotton or woolen mills and in furniture factories are examples of such groups, as are barbers, and operatives in shoe and clothing factories. Among white collar workers, fewer than one in 10 of the accident fatalities occurred in the course of their employment. These workers included clerks, and other office workers, merchants and storekeepers, and store clerks and salesmen.[1]

1. Most Accidents Occur While Away From Work, Science News Letter 67:261 (April 23) 1955.

Polio Ahead: Reasons Behind 1956 Florida March of Dimes

Although the number of polio cases reported in Florida in 1955 was about two-thirds the average number of the previous five years, and less than one-third the number reported in 1954, Florida will still have polio problems in 1956. The Salk vaccine has proved to be a major weapon against paralytic poliomyelitis, but it has not yet won the war against this disease.

Continuing cooperation of physicians must be had both in administering the vaccine and in caring for patients already paralyzed and those who will be paralyzed in spite of the vaccine. The Salk vaccine is not 100 per cent effective, and it will take considerable time yet, perhaps years, before all persons most susceptible to paralytic poliomyelitis can be fully immunized against it.

The National Foundation for Infantile Paralysis, supported through public contributions to its January March of Dimes, has made an enviable record, both in this state and nationwide, for meeting the problems posed by paralytic polio. In 1955 the March of Dimes gave nearly 302,000 cc. of Salk vaccine without charge to the state of Florida to initiate a statewide vaccination program.

The results already reported from the use of the vaccine are most encouraging, but they must not be allowed to blind the eye of the medical profession to the road that still lies ahead. There remains a great need for additional research to improve the Salk vaccine, to determine the dura-

tion of immunity it effects (and conversely to determine the need for "booster shots") and to provide the best possible treatment for patients already or yet to be involved with paralytic poliomyelitis. There is also a vast need for the professional education of young men and women who will contribute to the necessary research and help give the needed treatment.

To pay for research, education and aid to polio patients, the March of Dimes needs $47,600,000 in 1956. Florida physicians, knowing both the need and the record, will want to support and urge their patients to support the 1956 March of Dimes in their own communities.

A brief review of the record of the National Foundation for Infantile Paralysis in Florida, where it has 68 local chapters, should help to orient physicians to the many services to patients and the professions which have been made possible by the March of Dimes since 1938, when the National Foundation was founded.

Over $4,730,000 has been spent by local chapters in Florida for the care of polio patients.

The Florida State Board of Health has had $31,900 in March of Dimes grants for virus research.

A total of 63 National Foundation scholarships and fellowships has been awarded to Florida residents.

Emergency aid in dollars and in equipment for polio patients has been generously supplied to Florida. In the first 10 months of 1955, for example, a total of $123,700 in emergency aid was sent to 25 Florida chapters by the national headquarters of the National Foundation. In the year 1954 the amount was over $387,000 to 34 chapters.

A total of 10 tank respirators, 4 chest respirators and 2 rocking beds was sent into Florida as emergency shipments in the first 10 months of 1955. The previous year Florida got 43 respirators and 16 rocking beds.

Graduate Medical Education

The Committee on Medical Postgraduate Course of the Florida Medical Association met in Jacksonville on October 20, 1955. At the meeting the graduate medical courses presented during the year and the attendance were analyzed.

The courses proposed for 1956 in which the Florida Medical Association will participate as co-sponsor are: Seminar on Ophthalmology and Otolaryngology, January 16-21, Miami Beach; Seminar on Cardiology, February 23-25, Jacksonville; the Twenty-Fourth Annual Graduate Short Course, June 25-29, Jacksonville; Seminar on Gastroenterology, tentative subject for a two and a half day course just prior to the Short Course in June; Seminar on Diabetes, October, Jacksonville. The College of Medicine of the University of Florida and the Florida State Board of Health also will sponsor all of these programs of graduate medical education.

Cardiology Seminar
February 23-25

The Seminar on Cardiology to be presented at the Duval Medical Center in Jacksonville on February 23-25 is being sponsored by the Duval District Heart Association in cooperation with the Florida Medical Association, the Florida State Board of Health, and the College of Medicine of the University of Florida. Members of the Florida Heart Association have been invited to participate in this program. Any physician of Florida is eligible to attend, and it is anticipated that expenses for this course will be deductible from income tax.

Details of the program have not yet been completed, but it is expected that one third of the lectures will be devoted to cardiac pathology of the adult, an equal amount of time to cardiology of children, and a like amount to surgical cardiology. The speakers will be asked to stress recent developments in interpretation of electrocardiograms.

Plans are under way to have at least two major surgical operations of the heart performed during the Seminar for the benefit of those surgeons now performing cardiac surgery, or those who are preparing themselves for this highly specialized type of surgery. Further details will be published in the February Journal, and programs will be mailed out to all physicians in the state.

American Academy of General Practice Scientific Assembly
March 19-22, 1956

The nation's family doctors will gather in Washington, D. C., March 19 through 22, for the Eighth Annual American Academy of General Practice Scientific Assembly. More than 5,000 physicians are expected to attend.

During the four day scientific meeting, which will be held in the Armory, the doctors will hear 26 outstanding speakers discuss important subjects ranging from cardiac emergencies to primary wound repair. They will visit more than 60 scientific and 250 technical exhibits. Highlights of the program include two live clinics, one on "Diagnosis and Treatment of Curable Heart Disease" and the other on "Management of Patients with Disabling Diseases," a symposium on Obstetrics, and an address by Surgeon General Leonard A. Scheele entitled "The Changing Pattern of Disease." Special tours through the National Institutes of Health at Bethesda, Md., have been arranged.

The Academy's policy-making Congress of Delegates will convene at 2 p.m. on Saturday, March 17. All sessions of the Congress and many social functions will be held in the Hotel Statler. The state officers' dinner is scheduled for Monday night, March 19, and the Congress of Delegates dinner the following night. On Wednesday evening, March 21, following induction ceremonies for Academy President-elect J. S. DeTar, M.D., of Milan, Mich., more than 3,000 guests will attend a President's reception and dance honoring John R. Fowler, M.D., of Barre, Mass., the president of the Academy.

Planned for the doctors' wives are a coffee hour hat show and a luncheon fashion show. They may also take interesting tours of the nation's capital. A special children's tour will include visits to the Federal Bureau of Investigation office, the Capitol Building, the Washington Zoo, and the Smithsonian Institution.

Atlanta Graduate Medical Assembly February 20-22, 1956

Attracting wider attendance and acclaim in medical circles each year, the Atlanta Graduate Medical Assembly, scheduled for February 20-22 in 1956, has streamlined and sharpened its agenda to incorporate the features which have attracted most favorable comment from the growing numbers of doctors who have been attending each year.

Dr. A. Cullen Richardson of Atlanta, this year's Chairman of the Assembly, promises another excellent speaking faculty, a feature that has been possibly the most outstanding attraction in the past.

"In addition, this year we have made a stronger attempt to group the speakers and discussion forums on each separate specialty and field of interest to practitioners, into a unified correlated 'package,' allowing those visiting doctors most interested in one specific field to attend and participate in the coverage of this field in a concentrated dose," Dr. Richardson stated. "Also this year, we are lengthening the time allowed for lunch and scheduling some of our 'round table discussion forums' to convene around the luncheon table, thus allowing more time for a leisurely luncheon meal and at the same time the opportunity to combine a little business with pleasure," Dr. Richardson added.

Other highlights of the 1956 Atlanta Graduate Medical Assembly include a more extensive social and entertainment program, especially those activities planned for the visiting doctors' wives, than ever before. Atlanta, known throughout the country for its hospitality, has gone all out from the standpoints both of the large group of host physicians and medical associations themselves and of the nonmedical people and entertainment facilities of the city itself, to welcome the nearly 2,000 doctors from all over the country who are expected.

Highlights of Southern Medical Association Houston Meeting

The official attendance at the Forty-Ninth Annual Meeting of the Southern Medical Association in Houston in mid-November approximated 5,000. The Shamrock was the headquarters hotel, and Texas hospitality was at its usual best.

The two general sessions of the membership were presided over by the President, Dr. R. L. Sanders of Memphis. Attendance at both sessions broke all records in recent years. Features of the general session on Monday, November 17, were the presidential address by Dr. Sanders and an address by Francis Pendleton Gaines, Ph.D., of Lexington, Va., President of Washington and Lee University. Dr. Gaines was the President's guest for the Houston meeting.

The Wednesday evening dinner meeting was highlighted by a brief business session, the election of officers, the installation of the incoming President, Dr. W. Raymond McKenzie of Baltimore, and the presentation of the Past President's Medal to the retiring President. In recognition of his 43 years of loyal and efficient service to

the association, Mr. C. P. Loranz, of Birmingham, the association's Advisor and Professional Relations Counselor, was presented with a special "Golden Anniversary Key."

The Scientific Assembly consisted of a broad scientific program presented in the 20 specialty sections of the association, representing the major medical and surgical specialties and general practice; 55 selected scientific exhibits by physicians; a capacity number of technical exhibits; and a special symposium on Geriatrics. This comprehensive program of postgraduate education was augmented and further specialized by the scientific programs of five societies which met jointly or conjointly with the association or some of its sections. Scheduled and conducted tours of the fabulous Texas Medical Center and other Houston medical facilities rounded out a significant meeting from the educational point of view.

The 1956 meeting will be a "Golden Anniversary" celebration in Washington, D. C. The dates are November 12 to 15. In 1957 the Southern Medical Association will return to Florida for its annual meeting, which is scheduled for Miami Beach, November 11 to 14.

Report of Delegates to American Medical Association 1955 Clinical Meeting

Social security, the report of the Committee on Medical Practices, grievance committees and revisions of the code of medical ethics were among the major subjects of discussion and action by the House of Delegates at the American Medical Association's Ninth Clinical Meeting held November 29-December 2 in Boston.

Named as the 1955 General Practitioner of the Year was Dr. E. Roger Samuel of Mount Carmel, Pa., whose selection by a special committee of the Board of Trustees was announced at the opening session on Tuesday. Dr. Samuel, a former member of the House of Delegates and a general practitioner for 35 years, received the medal and citation presented annually for community service by a family doctor.

Dr. Gunnar Gundersen, A.M.A. Board Chairman, who made the award to Dr. Samuel, also presented a special citation to Dr. Torald Sollmann of Cleveland, Ohio, charter member of the A.M.A. Council on Pharmacy and Chemistry for over 50 years and its chairman since 1936. Dr. Sollmann, 81 years old, was honored for his "outstanding service to the medical profession and on behalf of the advancement of medical science."

Total registration at the end of the third day of the meeting had reached 7,027, including 3,672 physicians.

Social Security

Major legislative policy action taken at the Boston meeting involved H.R. 7225, known as the Social Security Amendments of 1955. This bill, which was passed last summer by the United States House of Representatives and is now pending before the Senate Finance Committee, includes a proposal for federal cash benefits to selected individuals judged to be permanently and totally disabled. The House of Delegates adopted a substitute resolution proposed by the Reference Committee on Legislation and Public Relations to combine the intent of four resolutions and three supplementary reports of the Board of Trustees dealing with H.R. 7225 and other aspects of Social Security. The substitute resolution stated the following policy:

"That the American Medical Association reiterate in the strongest possible terms its determination to resist any encroachment upon the American system of medical practice which would be detrimental to our patients, the American people;

"That the American Medical Association urge and support the creation of a well-qualified commission, either governmental or private or both, to make a thorough, objective and impartial study of the economic, social and political impact of Social Security, both medical and otherwise, and that the facts developed by such a study should be the sole basis for objective nonpolitical improvements to the Social Security Act, for the benefit of all of the American people;

"That the American Medical Association pledges its wholehearted cooperation in such a study of Social Security in the United States, and will devote its best efforts to procuring and providing full information on the medical aspects of disability, rehabilitation and medical care of the disabled, and

"That copies of this resolution be transmitted to the President of the United States, to all

members of the Cabinet, to all members of the Congress, and to all constituent state medical associations."

OASI Coverage of Physicians

In another action on social security, the House passed the following resolution designed to determine the exact attitude of physicians toward compulsory or voluntary coverage under the social security system:

"Whereas, Misunderstanding exists about the position of the medical profession on the question of the inclusion of physicians in the Old Age and Survivors Insurance provisions of the Social Security Act; therefore be it

"Resolved, That the House of Delegates of the American Medical Association recommend to state societies that they poll their entire membership on this question and that the results of the poll be transmitted to the Board of Trustees of the American Medical Association as soon as possible."

Report on Medical Practices

The House passed a substitute resolution offered by the Reference Committee on Insurance and Medical Service to implement the findings and recommendations of the Committee on Medical Practices (Truman Committee), which studied the basic causes leading to certain unethical practices and unfavorable publicity. The resolution, adopted with the proviso that it is subject to review by legal counsel, includes the following points:

"That a Continuing Committee on Medical Practice be created in the American Medical Association to conduct a study of the relative value of diagnostic, medical and surgical services and to report its findings and recommendations to this House in the same manner as is now followed by other committees and councils of the Association;

"That this committee shall consist of five members of the House appointed by the Speaker, three of whom shall be general practitioners; . . .

"That this committee be directed to utilize all possible means to stimulate the formation of a department of general practice in each medical school;

"That the American Medical Association approve of the medical school teaching programs which afford the medical student opportunity for experience in the general practice of medicine;

"That the representatives of the American Medical Association on the Joint Commission on Accreditation of Hospitals be instructed to stimulate action by that body leading to the warning, provisional accreditation or removal of accreditation of community or general hospitals which exclude or arbitrarily restrict hospital privileges for generalists as a class regardless of their individual professional competence, after appeal to the Commission by the County Medical Society concerned;

"That this committee cooperate in every way and assist the Public Relations Department of the American Medical Association to present a program of public education designed to bring about a better understanding of all fields of medical practice, and

"That this committee use its full influence to discourage any arbitrary restrictions by hospitals against general practitioners as group or as individuals."

In a complementary action on the same subject, the House also approved a supplementary report of the Board of Trustees which included the following suggestions:

1. All nonsurgical groups should be asked for their suggestions and cooperation in carrying out a public education program on the value of diagnostic and medical work.

2. The various specialty boards should be encouraged to reappraise the practice restrictions on their board diplomates.

3. The American Medical Association should continue to discourage arbitrary restrictions by hospitals against general practitioners.

4. Organized medicine is "ready, willing and able to solve satisfactorily its own problems, and such assurance should be given to the American Hospital Association or any other group concerning itself with such problems."

Guides for Grievance Committees

The House approved the report of the Committee to Recommend Guides for Grievance or Mediation Committees and commended the committee for "their superb approach to this problem." Purpose of the guides is "to promote general uniformity of organization and function of grievance committees — and better understanding of their purposes — without interfering with the inherent autonomy of constituent medical associations. Constituent associations are therefore urged to implement these guides without delay."

The Reference Committee on Miscellaneous Business made the following recommendations which were adopted by the House:

"Your reference committee desires to support the recommendation that a brochure be published promptly which will outline the recommendations regarding the activities of Grievance Committees and that this brochure be given wide distribution.

"We recommend also that there be an appendix to this brochure in which additional, practical suggestions shall be included.

"We desire also to support the contention that there should be no equivocation concerning the naming of such committees and we recommend that a uniform policy be adopted in which they are called frankly 'Grievance Committees.'

"Finally, your reference committee recommends that because of the many variables, including the laws of the several states, which may influence the operations or procedures followed by State Grievance Committees, legal counsel shall be sought at the local level within the states."

Medical Ethics

A proposed revision of the "Principles of Medical Ethics and Precepts of Manners of the American Medical Association" was submitted to the House by the Council on Constitution and Bylaws. The following reference committee suggestion was adopted by the House:

"In discussion it became evident that there was need for wide distribution of these principles and careful study of the proposed changes not only by this Reference Committee but also by all members of the House and in fact all members of the Association. It seemed desirable also that next June the Council on Constitution and By- the two Councils (Council on Constitution and Bylaws and the Judicial Council) should meet at the next annual session of the House to be in joint session to consider these proposals. Your Reference Committee therefore recommends that these proposals be tabled for further consideration held in Chicago in June, 1956.

"In the meantime, it is recommended that these proposals in their entirety be widely publicized and that consideration be given to publishing, in the Journal of the American Medical Association and also in state medical journals, these proposed changes in the Principles. It is also recommended that consideration be given to the mailing of copies to each member of the Association. Finally, your Reference Committee recommends that prior to the meeting in Chicago laws and the Judicial Council meet in joint session to consider these proposed changes."

In another action on revisions of medical ethics, the House also approved a plan requiring that all resolutions dealing with changes in the Principles of Medical Ethics shall be considered over a period between sessions of the House before final adoption.

Miscellaneous Actions

Among many other actions on a variety of other subjects, the House of Delegates also:

Recommended that the Board of Trustees give consideration to a dues increase for all Association members, with the increase designated for contribution to the American Medical Education Foundation;

Adopted a resolution on the practice of pathology declaring opposition to "the division of any branch of medical practice into so-called technical and professional services;"

Recommended that further purchase and distribution of Salk polio vaccine be carried on by the presently available commercial avenues used for other immunizing agents, and that all vaccines, once proven, should enter the usual channels of distribution;

Approved appointment of an A.M.A. committee to study the prevention of highway accidents;

Commended the Women's Auxiliary of the A.M.A. for its financial contributions in support of medical education and requested the Auxiliary to continue its active efforts;

Commended the Sears Roebuck Foundation for its thoughtfulness and foresight in sponsoring the new plan for financial assistance in establishing medical practice units;

Received progress reports from the Commission on Medical Care Plans and from the A.M.A. Law Department on its studies of professional liability;

Approved a Board of Trustees recommendation that the State Journal Advertising Bureau be separated from the American Medical Association and be given full autonomy;

Congratulated the physicians of Iowa for their efforts in supporting the position that the practice of medicine is the right of the individual, and

Approved the selection of Minneapolis for the 1958 Clinical Meeting and Chicago for the 1960 Annual Meeting.

Opening Session

Dr. Elmer Hess, A.M.A. President, told the opening session of the House that complacency should be regarded as the medical profession's greatest enemy. Although good progress is being made in informing the public and the profession of the objectives of organized medicine, he said, educational efforts must be intensified and the list of physicians' tangible accomplishments for the health benefit of the public must be increased.

Dr. Leo H. Bartemeier, Chairman of the A.M.A. Council on Mental Health, told the House that the new Joint Commission on Mental Illness and Health will be ready to embark on its nationwide study and re-evaluation of the human and economic problems of mental illness after the first of the year. Dr. Bartemeier, who is Chairman of the Board of Trustees of the Commission, appeared before the House to explain the functions of the new commission, which was organized to carry out the Mental Health Study Act passed by the Congress earlier this year without a dissenting vote in either house.

Medical Education Contributions

The A.M.A. Board of Trustees announced that it again has appropriated $100,000 to be contributed to the American Medical Education Foundation for the support of medical schools. The California Medical Association presented a $25,000 check to the AMEF, and the Utah State Medical Society announced an $11,000 contribution.

Respectfully submitted,
Louis M. Orr, M.D.
Reuben B. Chrisman Jr., M.D.
Francis T. Holland, M.D.

Editor's Note: The complete report of actions of the House of Delegates began in the December 24 issue of the Journal of the American Medical Association.

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. E. Frank McCall of Jacksonville announce the birth of a son, Eugene Franklin Jr., on November 2, 1955.

Dr. and Mrs. Robert J. Boucek of North Miami Beach announce the birth of a daughter, Mary Elizabeth, on October 15, 1955.

Marriages

Dr. Jack O. W. Rash of Miami and Mrs. Diana Woods Crutcher were married November 20, 1955, in Richmond, Ky.

Dr. Thomas B. Strozier of Miami and Miss J'neese Marie Altman were married November 26, 1955, in New Smyrna, Fla.

Deaths — Other Doctors

Sprinkle, Davis Lee, Dallas, Texas ... Aug. 27, 1955

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Bieber, Gustave F., Fort Myers
Carter, Donald D., St. Petersburg
Corse, Herbert L., Jacksonville
Davis, James M., Jacksonville
Ferguson, Emmet F. Jr., Jacksonville
Jaslow, Albert C., Key Biscayne
Kann, Solomon, Miami Beach
Kimbell, Fariss D. Jr., Pensacola
Long, Frank G., Jacksonville
McNally, Francis J., Pompano Beach
Miller, Samuel R. Jr., Crystal River
Smith, Daniel C., Fort Lauderdale
Stromberg, William, Jacksonville

Medical Officers Returned

Dr. Fred W. Alsup, who entered military service on March 19, 1953, was released from active duty on March 14, 1955 with the rank of captain, U. S. Army. His address is 623 22nd St. South, St. Petersburg.

Dr. John A. Lauer Jr., who entered military service on January 18, 1953, was released from active duty on June 1, 1955 with the rank of captain, U. S. Air Force. His address is 1725 Gulf-to-Bay Blvd., Clearwater.

Dr. John M. Malone, who entered military service on January 5, 1953, was released from active duty on October 5, 1954 with the rank of lieutenant, U. S. Naval Reserve, His address is Box 212, Green Cove Springs, Fla.

Dr. Paul W. Morgan, who entered military service on November 10, 1953, was released from active duty on November 9, 1955 with the rank of lieutenant commander, U. S. Naval Reserve. His address is Bowman Gray School of Medicine, c/o Ophthalmology Dept., Winston-Salem, N. C.

Dr. David H. Varn Jr., who entered military service on July 1, 1953, was released from active duty on June 30, 1955 with the rank of captain, U. S. Army. His address is 38 W. Broadway, Fort Meade.

Even though doctors give freely of time and labor to the public for the care of indigents, there are no indications, except for lip service, that the public appreciates our generosity.

—*Picomeso Mail Bag, Pinellas C.M.S.*

STATE NEWS ITEMS

The Eighth Mid-Winter Scientific Meeting of the Florida Obstetric and Gynecologic Society was held at Miami, December 2-4, 1955. Approximately 100 physicians attended.

The scientific program began Saturday afternoon, December 3, and continued through Sunday morning. Guest speakers were Dr. Robert N. Creadick, Duke University School of Medicine, Durham, N. C.; Dr. C. Hampton Mauzy, Bowman Gray School of Medicine, Winston-Salem, N. C.; Dr. John S. Fish, Emory University School of Medicine, Atlanta, and Mr. C. Joseph Stetler, director of the Law Department, American Medical Association.

With the exception of Mr. Stetler, each speaker delivered three addresses. Dr. Creadick discussed "The Physician's Part in Premarital Counseling," "Some Psychosomatic Aspects of Gynecologic Practice" and "Persistent Vulvitis." Dr. Mauzy's addresses were "Post-Operative Care," "Solid Ovarian Tumors" and "Urinary Stress Incontinence in Women," and Dr. Fish's "The Management of Threatened Abortion," "The Expectant Treatment of Placenta Previa" and "Retinal Changes in Pregnancy Hypertension." Mr. Stetler discussed "Legal Aspects of Artificial Insemination."

Dr. John D. Milton of Miami, president of the Florida Medical Association, has returned from Chicago where he attended the Fourth Annual Clinical Meeting of the American Academy of Obstetrics and Gynecology held there December 12-14.

Drs. James N. Patterson of Tampa and James J. Griffitts of Miami were among Florida physicians who attended the Eighth Annual Meeting of the American Association of Blood Banks held the latter part of November in Chicago. Dr. Griffitts was installed as president of the Association. Dr. Patterson served as chairman of the nominating committee.

The second annual one day course stressing diagnosis and management of a few of the more common skin diseases is being held at the Louisiana State University School of Medicine January 21. Physicians interested in the course should write the Department of Dermatology of the medical school at New Orleans.

Thirty Florida physicians have become fellows of the American College of Surgeons. Included in the group are Drs. George M. Stubbs and Jonathan H. Wood, Jacksonville; Dr. David W. Goddard, Daytona Beach; Dr. Willis D. Bidgood, DeLand; Dr. John E. Daughtrey, Lakeland; Drs. Harold W. Johnston, James D. Moody and Ernest J. Stevens, Orlando; Drs. Pascal G. Batson Jr. and Alpheus T. Kennedy, Pensacola, and Dr. Francis T. Holland, Tallahassee.

Dr. Curtis D. Benton Jr. of Fort Lauderdale has been awarded a certificate of appreciation for serving as instructor in ophthalmology at the October meeting of the American Academy of Ophthalmology and Otolaryngology held in Chicago.

Drs. Edward F. Fox and Reuben B. Chrisman Jr. announce the opening of their new office at 356 Alhambra Circle, Coral Gables.

Dr. James R. Duke, the son of Dr. R. Renfro Duke of Tampa, has joined the staff of Wilmer Institute at the Johns Hopkins Hospital in Baltimore.

The College of Medicine of the University of Florida has announced the availability of fellowships and assistantships for graduate study in the basic medical sciences and for graduate work in anatomy, biochemistry, microbiology, pathology, pharmacology and physiology. Additional information is available from the Office of the Dean, College of Medicine, University of Florida, Gainesville.

The Scientific Work Committee of the Florida Medical Association met in Jacksonville late in November for consideration of the program for the Scientific Assembly of the Eighty-Second Annual Meeting of the Association being held at Miami Beach, May 13-16, 1956. Members of the Committee present were Dr. Donald F. Marion, Miami, chairman, Dr. Richard Reeser Jr., St. Petersburg, and Dr. Scottie J. Wilson, Fort Lauderdale.

Dr. Edwin W. Brown of West Palm Beach, president of the Palm Beach County Medical Society, discussed "Medical Legislation" at the first fall meeting of the Woman's Auxiliary to the Society held at the home of Mrs. William H. Proctor.

Dr. Fred I. Dorman Jr. of Lakeland was principal speaker at the November meeting of the Parents' Group of the United Cerebral Palsy Affiliate of Polk County. The meeting was held at Lakeland.

Dr. Marjorie L. Warner of Bradenton, president of the Manatee County Medical Society, addressed the first fall meeting of the Woman's Auxiliary to the Society held at the home of Mrs. Richard Meaney at Palmetto. Dr. Warner discussed the importance of the Auxiliary and suggested ways in which the organization could assist physicians in their program for the advancement of medicine and public health.

Dr. Robert E. Raborn of Delray Beach has returned from Durham, N. C., where he attended a postgraduate course in internal medicine at the Duke University School of Medicine.

Dr. David R. Moomaw of Jacksonville was principal speaker at the first fall meeting of the Duval County Chapter of the Florida Society of Medical Technologists.

Dr. Lawrence J. Schneider of Daytona Beach addressed a recent meeting of the Rotary Club of that city.

Dr. Douglas R. Murphy of Venice has returned from Chicago where he attended the meeting of the American College of Surgeons.

Drs. Gordon H. McSwain and Charles H. Kirkpatrick of Arcadia attended a recent meeting of railway surgeons held at Savannah, Ga.

Dr. Richard H. Sinden of St. Petersburg has been elected president of the Florida Clinical Diabetes Association.

Dr. Joseph M. Bistowish Jr. of Tallahassee has been elected president of the Florida Academy of Preventive Medicine. Other officers chosen at the recent annual meeting were Dr. Turner E. Cato, Miami, first vice president; Dr. Frank M. Hall, Gainesville, second vice president, and Dr. Clarence L. Brumback, West Palm Beach, secretary-treasurer.

Dr. Raymond H. King of Jacksonville was principal speaker at a recent meeting of the Laryngectomees Club of that city. Dr. King discussed cancer treatment and related some of its history.

Dr. Lee Sharp of Pensacola has been elected second vice president of the Gulf Coast Clinical Society.

Dr. William H. Grace of Ft. Myers has returned from Savannah, Ga., where he attended a meeting of railway surgeons.

Dr. Robert J. Grayson of Miami Beach was principal speaker at a November meeting of the North Miami Beach Junior Chamber of Commerce.

Dr. Jack W. Fleming of Pensacola discussed the relation of tension and worry to physical illness at a recent meeting of the health division of the Escambia Community Council held at Pensacola.

Dr. Miles J. Bielek of Fort Lauderdale has returned from Chicago where he attended the annual meeting of the American College of Gastroenterology.

Dr. G. Dekle Taylor of Jacksonville attended the annual meeting of the American Academy of Ophthalmology and Otolaryngology in Chicago the week of October 10 and participated in the scientific program by presenting a paper entitled "The Problem of Reflex Esophagitis."

Dr. Sherman B. Forbes of Tampa has been chosen president-elect of the Section on Ophthalmology and Otolaryngology of the Southern Medical Association.

Dr. Charles C. Grace of St. Augustine has returned from Chicago where he attended the annual meeting of the American Academy of Ophthalmology and Otolaryngology.

Miss Dorothy M. Smith of Hartford, Conn., has been appointed dean of the College of Nursing at the University of Florida. Formerly assistant director of nursing at the Hartford Hospital School of Nursing, Miss Smith will join the staff at J. Hillis Miller Health Center on February 1, 1956.

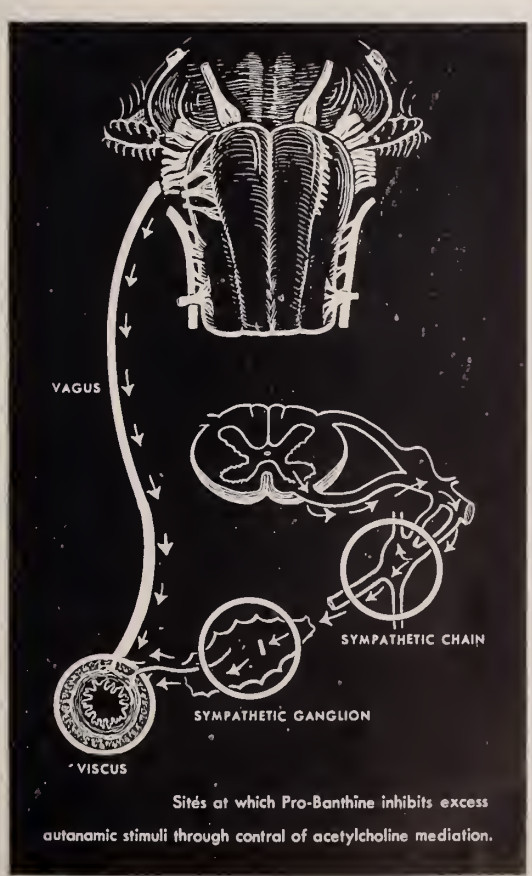
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1. Schwartz I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: Gastroenterology *25*:416 (Nov.) 1953.
2. Roback, R. A., and Beal, J. M.: Gastroenterology *25*:24 (Sept.) 1953.

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SEARLE

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Mr. Marshall D. Brainard of Jacksonville has been appointed executive secretary of the Duval County Medical Society following action by Society members at their November meeting. Mr. Brainard had been serving on a temporary basis since May, 1955.

Drs. Carl S. McLemore and G. Tayloe Gwathmey of Orlando were among the group of Florida physicians who attended the meeting of the American Academy of Ophthalmology and Otolaryngology held in Chicago the middle of October.

Drs. W. Jerome Knauer Sr. and Louis A. Wilensky of Jacksonville have returned from Chicago where they attended the meeting of the American Academy of Ophthalmology and Otolaryngology.

Dr. George Lister of Miami was guest speaker at a recent meeting of the Mothers-Of-Twins Club of that city held at the Dade County School Board Administration Building.

Dr. Edward R. Annis of Miami was principal speaker at a recent meeting of the Miami Junior Chamber of Commerce.

Dr. Collin F. Baker Jr. of Tampa discussed the cost of medical care at a late November meeting of the Tampa Junior Chamber of Commerce. As part of his address, Dr. Baker enumerated some of the common complaints he hears against physicians in his capacity as chairman of the Committee on Public Relations of the Hillsborough County Medical Association.

Dr. William Y. Sayad of West Palm Beach attended the meeting of the American Academy of Ophthalmology and Otolaryngology held in Chicago in October.

Dr. Wesley W. Wilson of Tampa has returned from Houston, Texas, where he participated in the annual meeting of the Southern Dermatological Association.

Dr. George H. Putnam of Gainesville has been elected president of the Gainesville Shrine Club.

Dr. Mozart A. Lischkoff of Pensacola has returned from Chicago where he attended the recent meeting of the American Academy of Ophthalmology and Otolaryngology.

Dr. Sherman B. Forbes of Tampa was a guest at the October meeting of the Central Illinois Society of Ophthalmology and Otolaryngology held at Bloomington, Ill., in honor of Dr. Watson Gailey of the Gailey Eye Clinic of that city. After attending the annual meeting of the American Academy of Ophthalmology and Otolaryngology held in Chicago, Dr. Forbes spent two weeks at various special clinics in New York City.

The first sectional meeting of the American College of Surgeons for the 1956 season is being held at Jacksonville January 16-18, 1956. Dr. Kenneth A. Morris of Jacksonville is chairman of the local advisory committee on arrangements. The sessions will be held in the George Washington Hotel.

Dr. R. Gaylord Lewis of West Palm Beach was principal speaker at the November meeting of District 9, Florida State Nurses Association, held at West Palm Beach. The title of Dr. Lewis' address was "Pre and Post-Operative Care of the Patient Having an Anesthetic."

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The University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology is being held at Miami Beach January 16-21, 1956. Headquarters hotel is the Sans Souci. Concurrent with the Seminar is the 1956 midwinter convention of the Florida Society of Ophthalmology and Otolaryngology being held on the afternoon of January 18 in the same hotel.

Drs. Edward R. Annis, Reuben B. Chrisman Jr. and W. Tracy Haverfield of Miami; Dr. Cecil M. Peek of West Palm Beach; Dr. H. Phillip Hampton of Tampa, and Dr. Francis T. Holland of Tallahassee attended the Regional Legislative Conference sponsored by the A. M. A. at Atlanta early in November. Dr. Chrisman was one of the presiding officers. He, also addressed the conference on the subject "Compulsory Disability Coverage Under Title II of the Social Security Act." Dr. Hampton, who is chairman of the Committee on Legislation and Public Policy of the Florida Medical Association, discussed "Federal Aid to Medical Education."

Dr. Nathaniel M. Levin of Miami was one of the principal speakers at the annual convention of the American Speech and Hearing Association held the middle of November at Los Angeles. The title of his paper was "Total Laryngectomy."

Dr. Wesley S. Nock of Coral Gables has been elected president of the Florida Pediatrics Society for the year which began January 1, 1956. Dr. Joel V. McCall Jr. of Daytona Beach has been chosen vice president and Dr. Henry G. Morton of Sarasota secretary-treasurer. Election of officers took place during the annual fall meeting of the Society.

CLASSIFIED

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OBITUARIES

Hermon Marshall Taylor

Dr. Hermon Marshall Taylor of Jacksonville died on Sept. 22, 1955, after suffering a coronary occlusion followed by cerebral thrombosis 11 days earlier. He was 74 years of age.

The son of the Reverend James Barnett Taylor, D.D., a Baptist minister, and Fannie Callendine Taylor, Dr. Taylor was born in Wilmington, N. C., on June 7, 1881. Of pure American stock, he numbered among his ancestors colonial governors of Massachusetts and Connecticut, a signer of the Declaration of Independence, an officer of the Revolutionary War, and a president of Yale College. His father, a native of Richmond, Va., and a graduate of the University of Virginia, served with distinction in J. E. B. Stuart's cavalry during the War Between the States. Later while teaching philosophy at Washington and Lee University in Lexington, Va., he resided in the old home of Stonewall Jackson, where Dr. Taylor spent his early life.

In 1903, Dr. Taylor was awarded the degree of Doctor of Medicine by Emory University in Atlanta. Later he engaged in postgraduate study at the Medical College of Virginia in Richmond and had special training at the New York Eye and Ear Infirmary, where he was associated in practice with the eminent Dr. Cornelius G. Coakley. He also studied otolaryngology in the clinics of Vienna, Munich and Paris. During World War I, he served as a captain in the Medical Corps of the United States Army.

Dr. Taylor entered the practice of medicine in Jacksonville in 1911 and continued to engage in the practice of his specialty of otolaryngology in that city for 44 years. Through the years he served locally as consulting otolaryngologist to the Duval Medical Center, to Riverside Hospital, and to St. Luke's Hospital where at one time he served as chief of staff. He was also a member of the staff of St. Vincent's Hospital, Hope Haven Hospital, and Brewster Hospital. For many years he was consulting otolaryngologist to the Florida East Coast Hospital and the State School for the Deaf and Blind at St. Augustine.

Prominent in business, civic and social affairs, Dr. Taylor was a leader in promoting the welfare and progress of Jacksonville. For many years he served on the board of directors of the Atlantic National Bank. He held membership in the Florida Yacht Club and in the Timuquana Country Club, of which he was a charter member. A devout member of the Riverside Baptist Church, he was a past chairman and, at the time of his death, a member of its board of deacons and a trustee. He was in the forefront of the movement to bring the Baptist Hospital to Jacksonville and while participating in the opening ceremonies of this institution, for which he had labored long and arduously and had served in various official capacities as the project developed, he was stricken with the illness which terminated fatally.

Dr. Taylor had a remarkable record of leadership in his profession locally and at the state and national levels. He was a member of the Duval County Medical Society and served as its president in 1930. A life member of the Florida Medical Association, he was its president in 1923 and for a time represented it in the House of Delegates of the American Medical Association. He was a founder member and first president of the Florida Society of Ophthalmology and Otolaryn-

(Continued on page 592)

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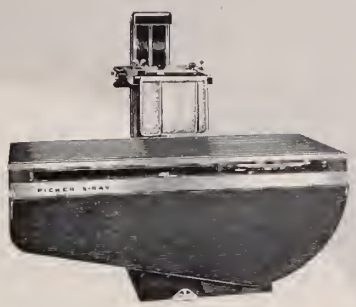
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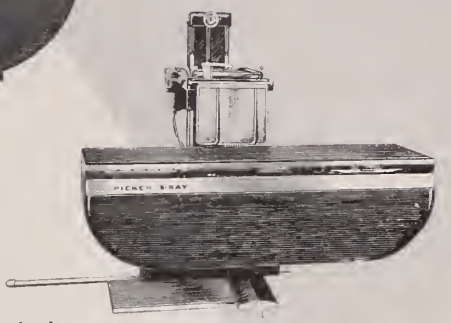
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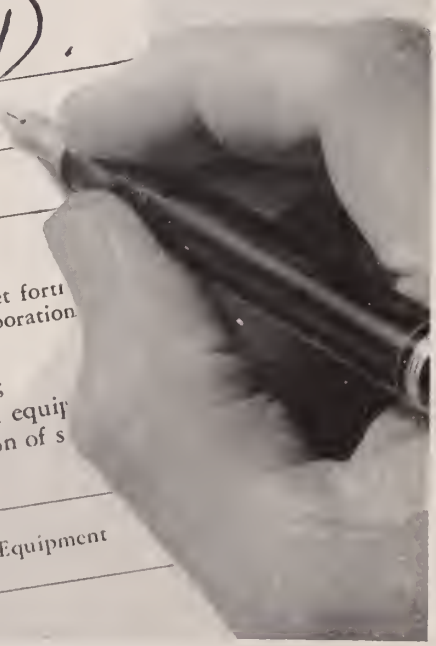
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Erythromycin in treatment of abscess

6/21/55

DISCHARGE SUMMARY

On 5/23/55 this patient (colored female, age 24) underwent an excisional biopsy of a breast tumor. On 5/24 tumor was removed and patient discharged from hospital on following day.

On 6/3/55 patient was readmitted because of purulent discharge from wound. On 6/3 a hemolytic Staph. aureus (coag. +) was isolated from abscess with the following disk sensitivities: penicillin, 1.5 units; erythromycin, 10 mcg; tetracycline, 10 mcg. Patient was placed on penicillin, 600,000 units b.i.d. for 10 days. On this schedule patient improved but progress was unsatisfactory and wound continued to discharge small amount of purulent material.

On 6/13 penicillin was discontinued and erythromycin started in dosage of 200 mgm. q.i.d. By 6/17 the discharge had stopped and wound was completely healed by 6/19. Erythromycin was continued until the patient was discharged from hospital on 6/21. Temp. was normal throughout hospital stay.

Final diagnosis: breast abscess due to Staph. aureus.

Result: rapid and complete recovery on erythromycin following failure of penicillin.

Communication to Abbott Laboratories.

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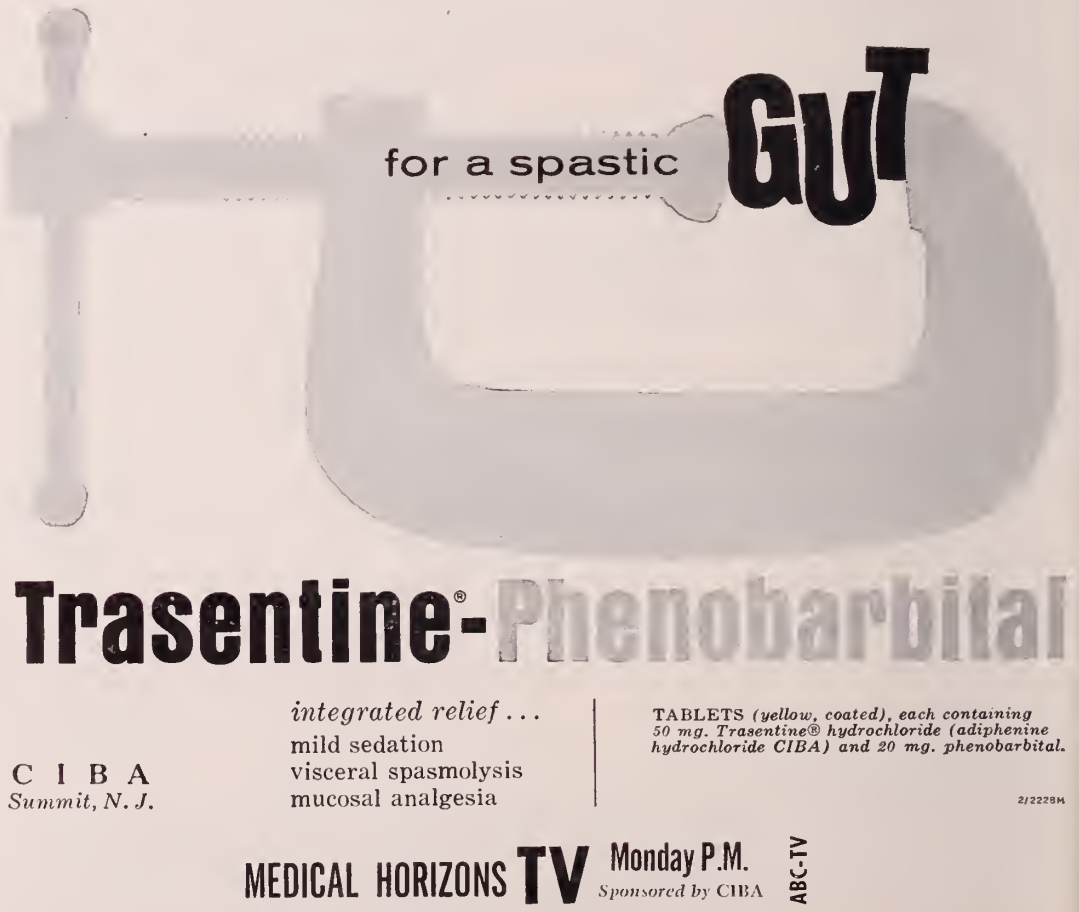
(Continued from page 588)

gology. From the time of its founding, he was the head of the Department of Otolaryngology of the Graduate School of Medicine of the University of Florida and was the founder of its Midwinter Seminar in Ophthalmology and Otolaryngology. It was at his instigation that Florida became the second state in the nation to pass the lye legislation which since has become widespread.

Through the years Dr. Taylor served the Southern Medical Association in several official capacities, notably as secretary and chairman of the Section on Ophthalmology and Otolaryngology, and as a member for six years and for two years chairman of the Council. In 1935 he became its president. In addition to his service in the House of Delegates of the American Medical Association, he served in 1938 as chairman of the Section on Laryngology, Otology and Rhinology of that organization and for 12 years was chairman of its Committee on Otorhinologic Hygiene of Swimming. A fellow of the American College of Surgeons, he was elected in 1950 to its Board of Governors.

To the national organizations of his specialty Dr. Taylor gave generously of his time and talents. In 1935 he was president of the American Bronchoscopic Society, now known as the American Broncho-esophagological Association, and in 1944 became president of the American Laryngological, Rhinological and Otological Association. The American Laryngological Association, of which he was president in 1952, bestowed upon him its highest honors for outstanding achievements — the Casselberry Award in 1939 and the James E. Newcomb Award in 1950. He served these specialty organizations in numerous official capacities other than the presidency, including membership on the editorial board of their official publications.

Dr. Taylor's many contributions to the literature of his specialty include reports of his fruitful clinical research on various subjects, notably the deleterious effect of sandspurs upon the membrane of the larynx and lungs, the causes and prevention of otologic disease and sinusitis following swimming and diving, and prenatal medication in relation to the fetal ear. He contributed the chapter on "Deafness from Drugs and Chemical Poisons" in Fowler's Medicine of the Ear and the chapters on "Congenital Deafness" and



Pork in the Human Dietary

Pork may be looked upon as an important factor in America's general health and well-being. The average intake of pork in America is about 46 pounds of lean pork and 20 pounds of bacon and salt pork per person each year.[1] But America's demand for pork goes further than taste appeal and deeper than mere statistics. Pork makes a valuable contribution to day-in-and-day-out nutrition.

Pork rates among the foremost sources of thiamine. As a source of all other B vitamins and many essential minerals, such as iron and phosphorus, pork meat is considered an important dietary constituent.

Lean pork is virtually completely digestible. Its protein serves to promote growth and aid in the maintenance of tissue cells. Like all high quality protein, that of pork aids in the elaboration of protein hormones, enzymes, and antibodies.

Pork constitutes a valuable part of the daily diet (Table I), and also contributes importantly to the nutrition of the pregnant woman (Table II).

Pork and pork products have won America's favor by their unique combination of economy, palatability, and nutritional value.

1. Consumption of Food in the United States, 1909-1952, Washington, D.C., United States Department of Agriculture, Bureau of Agricultural Economics, Agricultural Handbook No. 62, September, 1953.

2. Watt, B.K., and Merrill, A.L.: Composition of Foods—Raw, Processed, Prepared, Washington, D.C., United States Department of Agriculture, Agricultural Handbook No. 8, 1950.

3. Bowes, A. deP., and Church, C.F.: Food Values of Portions Commonly Used, ed. 7, Philadelphia, Anna dePlanter Bowes, 1951.

4. Cheldelin, V.H., and Williams, R.J.: Studies on the Vitamin Content of Tissues, II, Houston, Texas, University of Texas Publication No. 4237, 1942.

5. Schweigert, B.S.; Nielsen, E.; McIntire, J.N., and Elvehjem, C.A.: Biotin Content of Meat and Meat Products, J. Nutrition 26:65 (July) 1943.

6. Scheid, H.E., and Schweigert, B.S.: The Vitamin B_{12} Content of Meat, Annual Report, An Outline of Research During the Fiscal Year 1953-54, Chicago, American Meat Institute Foundation, Bull. 22, 1955.

7. Estimated on basis of protein content of meats. Sherman, H.C.: Food Products, ed. 4, New York, The Macmillan Company, 1948 p. 155.

8. Recommended Dietary Allowances, Washington, D.C., National Academy of Sciences—National Research Council, Publication 302, 1953.

TABLE I

Cooked Pork Chops, Ham, and Pork Sausage
Nutrients and Calories Provided by 3-Ounce Portions

	Protein Gm.	Thiamine mg.	Niacin mg.	Riboflavin mg.	Iron mg.	Phosphorus mg.	Calories
Pork Chops, without bone, cooked, 3 oz.[2]	20	0.71	4.3	0.20	2.6	200	284
Ham, without bone, cooked, 3 oz.[2]	20	0.45	4.0	0.20	2.6	202	338
Pork Sausage, cooked, 3 oz.[3]	14	0.42	2.8	0.20	2.1	139	396

3.5 ounces of fresh pork loin, equivalent to approximately 3 ounces of cooked loin, contains 0.47 mg. pantothenic acid;[4] 0.10 mg. pyridoxine;[4] 0.005 mg. biotin;[5] 36 mg. inositol;[4] 0.08 mg. folic acid;[4] 0.0027 mg. vitamin B_{12};[6] 63 mg. chlorine;[7] 0.1 mg. copper;[7] 20 mg. magnesium;[7] 280 mg. potassium;[7] 70 mg. sodium;[7] and 0.01 mg. manganese.[7]

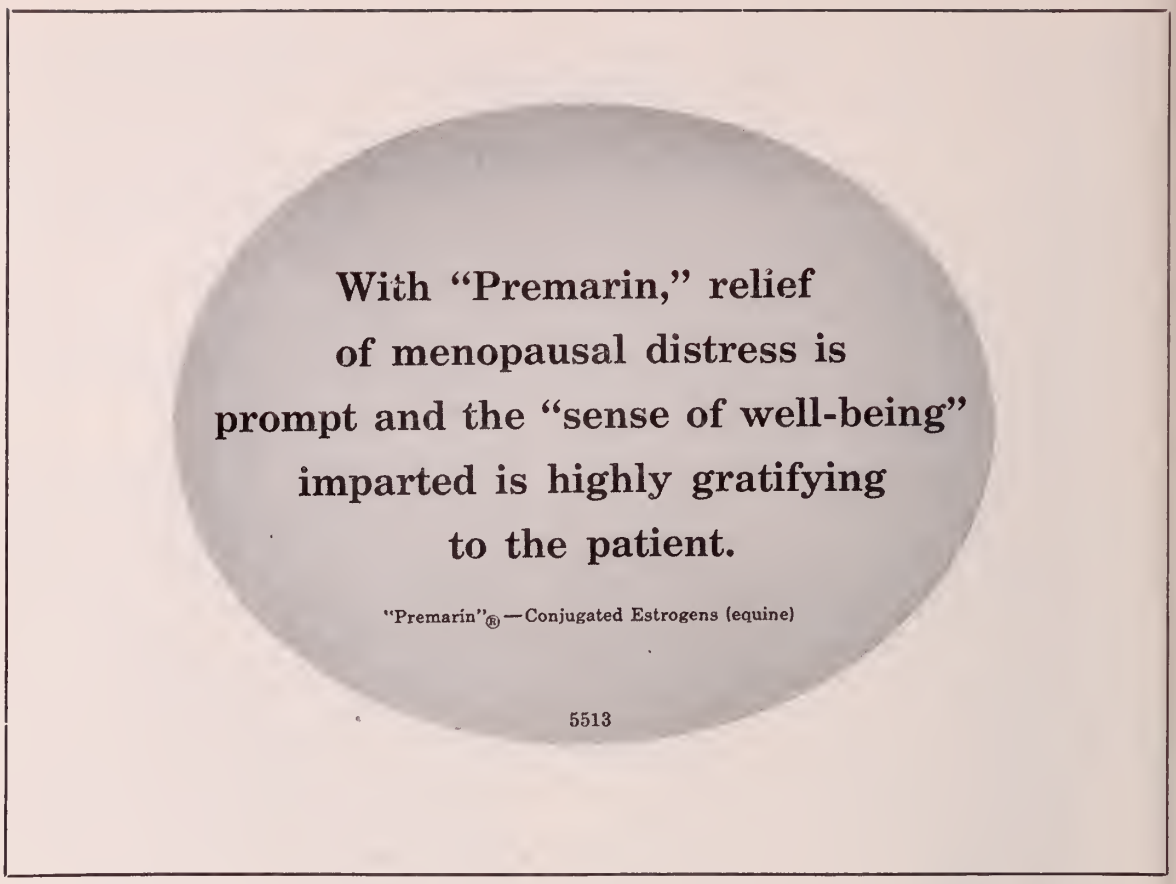
TABLE II

Nutrients and Calories of Cooked Pork Chops (3 ounces) Expressed as Percentages of Recommended Daily Dietary Allowances[8]

Percentages of Allowances for:	Protein	Thiamine	Niacin	Riboflavin	Iron	Phosphorus	Calories
Girls, 13-15 years of age; weight, 108 lb.; height, 63 inches.	25%	55%	33%	10%	17%	15%	11%
Women, 25 years of age; weight, 121 lb.; height, 62 inches.	31%	59%	36%	14%	22%	17%	12%
Pregnant Women (3rd trimester)	25%	47%	29%	10%	17%	13%	11%

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

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"Otorhinologic Hygiene of Swimming" in The Encyclopedia of Medicine. His motion picture on "The Hygiene of Swimming" has been used extensively in schools and universities throughout the country.

Dr. Taylor is survived by his widow, the former Miss Pallie Elaine Dekle of Marianna; one daughter, Mrs. Margaret Taylor Pattison, of Santa Monica, Calif.; two sons, Coakley Taylor, of Jacksonville, and Dr. G. Dekle Taylor, associated with his father in the practice of otolaryngology in Jacksonville; and six grandchildren, Peggy Taylor Pattison, Pamela Williams Pattison, Polly Abbott Pattison, Coakley Chadwick Taylor, Judith Marie Taylor and Jonathan Dekle Taylor.

Silas Curtis Johnson

Dr. Silas Curtis Johnson of Lakeland died in a Wabash, Ind., hospital late in August after a brief illness. He was 85 years of age.

Dr. Johnson, the son of Robert W. and Sarah Jane Johnson, was born in Indiana in 1869 and received his education in his native state. Upon graduation from DePauw University he attended the University of Indiana School of Medicine in Indianapolis and was awarded the degree of Doctor of Medicine in 1897. He practiced medicine and surgery in Chicago for many years before locating in Miami in 1939. During World War II, although in his seventies, he worked untiringly day and night not only caring for his own patients but for those of his colleagues who had been called into military service.

Although only his later years were spent in Florida, Dr. Johnson built up a large practice and was greatly revered. At one time he held the assignment of medical doctor for the Hialeah Race Track. At the age of 75, he was initiated into the Biscayne Bay Masonic Lodge, and his retentive memory as he reported on the degrees amazed the officers of the lodge. At the age of 82 he decided to retire and thereafter resided in Lakeland.

Upon retirement he was made a privileged member of the Dade County Medical Association, with which he had long been affiliated. Since 1940 he had been a member of the Florida Medical Association, in which at the time of his death he held honorary life membership. He was also

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a member of the American Medical Association.

After previous marriages in 1909 and 1930, Dr. Johnson in 1951 was married to Lulu B. Hutchens, who survives him. Also surviving are two daughters, Mrs. Carl Schmalzried, of Wabash, Ind., and Mrs. Walter Lerche, of Glen Ellyn, Ill.; one son, Russell C. Johnson, of San Francisco; two stepsons, Harry J. Hutchens, of California, and Howard T. Hutchens, of Lakeland; one brother, Myron Johnson, of Minnesota; and five grandchildren.

Will L. Wood

Dr. Will L. Wood of New Smyrna Beach died at Patrick Air Force Base Hospital in Cocoa on Oct. 8, 1955, following an operation. He was 66 years of age. Interment took place in Orlando.

Born in Camilla, Ga., on Sept. 29, 1889, Dr. Wood was the son of Dr. Will Saunders Wood and the grandson of Dr. John Abram Wood. He received his academic training at Mercer University and his medical training at Emory University School of Medicine, where he was awarded the degree of Doctor of Medicine in 1914. He was a member of the Phi Delta Theta fraternity and the Theta Kappa Psi medical fraternity.

Dr. Wood served in the Public Health Service in World War I, changed to the Army Reserves and was a graduate of the Command and General Staff School. In World War II he served as a full colonel and was retired from the Army on Sept. 30, 1945 with the permanent rank of colonel. Prior to World War II he practiced his specialty of roentgenology at Lake County Medical Center in Eustis, where he was a staff member and part owner of Waterman Memorial Hospital. After the war he practiced medicine in New Smyrna Beach until his retirement because of ill health and was on the staff of the Fish Memorial Hospital there. He was a member of the Retired Officers Association, the New Smyrna Beach American Legion Post, and St. Paul's Episcopal Church.

An honorary life member of the Volusia County Medical Society, Dr. Wood was also a member of the Florida Medical Association, holding honorary status. Through the years he held membership in the American Medical Association.

Surviving are the widow, Mrs. Lucy Fleming Wood, of New Smyrna Beach; two daughters, Mrs. Marcel Boudet, of Vero Beach, and Mrs. Marie McEver, of Plant City; and six grandchildren.



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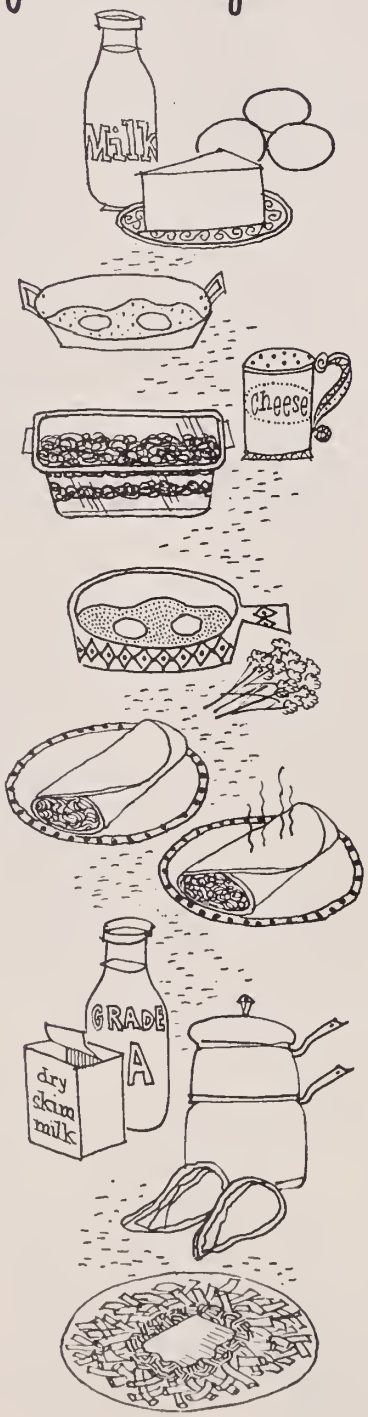
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Eggs baked in pimiento-flecked cheese sauce are hard to resist. Or, if your patient prefers, the sauce can be poured over hard-cooked eggs.

A casserole of eggplant and tomatoes layered alternately with ricotta or cottage cheese makes a satisfying entree. Add a sprinkle of grated parmesan with a fine Italian hand.

Your patient may like his eggs poached in tomato juice. Then serve them in a soup bowl with a frill of chopped parsley on top.

In these, the trio plays accompaniment—

Ham 'n' egg rolls come hot or cold. For hot, roll a warm slice of ham around eggs that have been scrambled with a pinch of savory. For cold, roll ham around egg salad mixed with cottage cheese.

Oyster stew can be creamy without cream when the milk is bolstered with dry skim milk powder. A pinch of thyme and some chopped parsley add savor.

Broiled salmon or tuna-burgers nestle nicely in a nest of noodles. A slice of cheese on top adds color and broils to a bubbling brown.

These suggestions are only a few of the possible combinations of this versatile trio. And the adequate protein nutrition they make possible, plus a liberal intake of fluids, may help establish a regimen that will please you both.

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104 calories, 17 mg. sodium/8 oz. glass (Average of American beers)

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1. McLester and Darby: "Nutrition and Diet in Health and Disease," ed. 6, Saunders, p. 195. 2. McCay, C. M., in Lansing: "Problems of Aging," ed. 3, Williams and Wilkins, 1952, p. 193. 3. Sebrell and Hundley, in Stieglitz: "Geriatric Medicine," ed 3, Lippincott, 1954, p. 189.

John Gordon DuPuis

Dr. John Gordon DuPuis of Miami died at his home on Sept. 17, 1955, within a week of his eightieth birthday.

A native Floridian, Dr. DuPuis was born at Newnansville on Sept. 23, 1875. He received his preliminary education in the public schools of Florida and then taught for several years in the public schools of Georgia, Kentucky and Florida preparatory to entering medical school. In 1898 he was awarded the degree of Doctor of Medicine by the University of Louisville School of Medicine and only recently he received a certificate of appreciation from that institution in recognition of his more than 50 years of service in the practice of medicine.

In October 1898 Dr. DuPuis arrived in the Lemon City section of the Miami area where he continued to practice medicine for 57 years. He

(Continued on page 600)

COMPONENT SOCIETY NOTES

Marion

The annual sea food supper of the Marion County Medical Society was held at the Wander Inn on Crystal River Tuesday evening, November 15. Invited guests were members of the Society's Woman's Auxiliary.

Pinellas

The December meeting of the Pinellas County Medical Society was held at the Lakewood Country Club. The program consisted of a discussion of "Medico-Legal Relationships" by Attorney Baya Harrison of St. Petersburg. Introductory remarks were made by Dr. Robert C. Lonergan.

Volusia

The Volusia County Medical Society held its monthly meeting Tuesday, November 8. Principal speaker was Dr. George T. Harrell Jr., dean of the College of Medicine of the University of Florida, who presented the academic and institutional program proposed for the new medical school. Following Dr. Harrell on the program was Mr. James C. Searles, a field representative of the radioactive pharmaceuticals department of Abbott Laboratories, who presented a paper on radioactive isotopes. Dr. Harrell discussed the paper with emphasis on the place of radioactive isotopes in clinical medicine today.



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immediately became a powerful figure in the community and through the years earned a national reputation for his contributions to medicine, education, religion and agriculture. In a book, entitled "A History of Early Medicine, Public Schools and Early Agricultural Relations in Dade County," published only last April, this versatile pioneer related many of his experiences and observations as an early Dade County agriculturist, educator, civic leader and practicing physician.

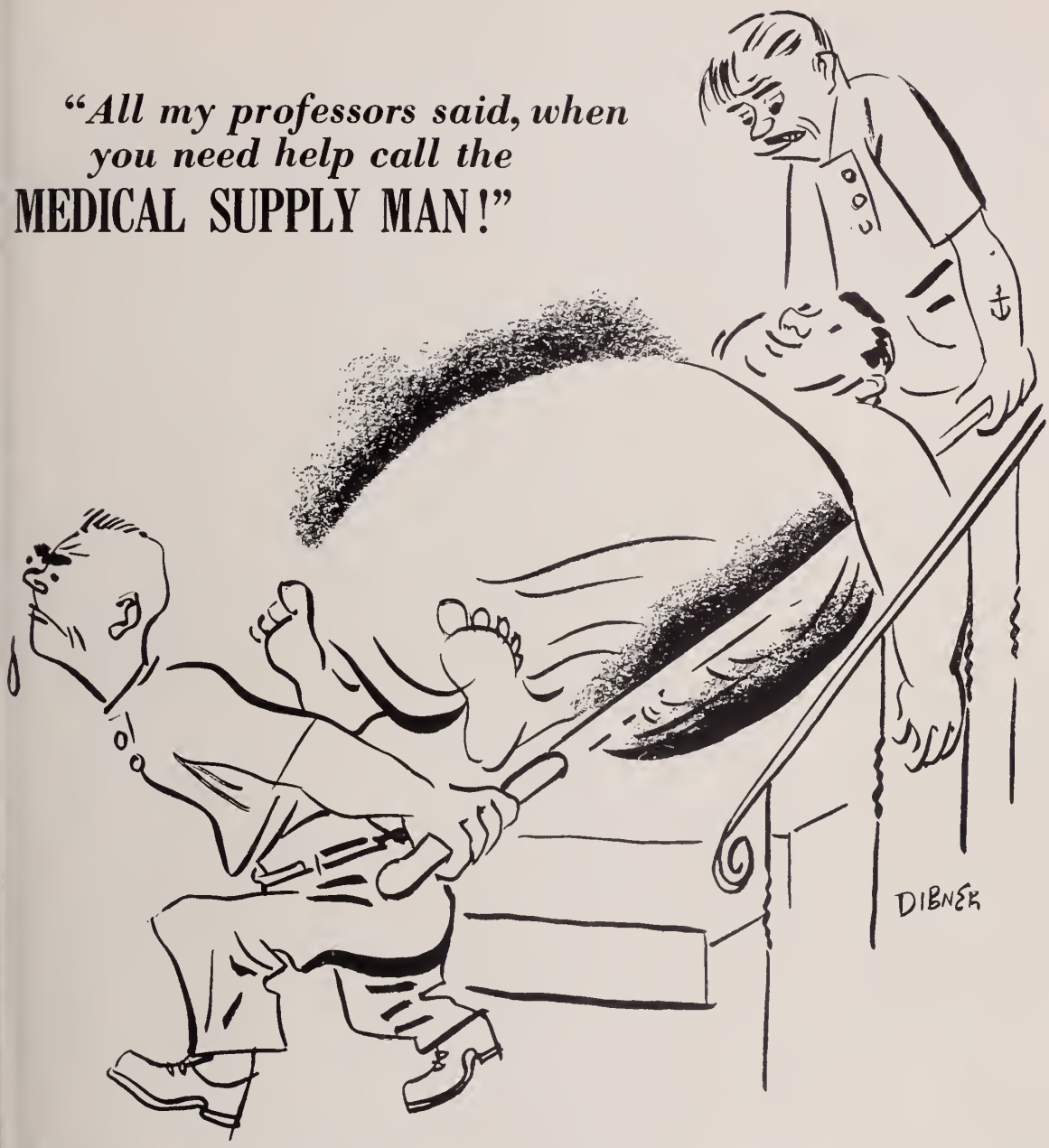
From 1900 to 1930 he was chairman of the board of trustees of District No. 3 of the Dade County School Board. Particularly notable in the educational field was his work in establishing the Dade County Agricultural High School, now known as Miami Edison High School. In civic projects, Dr. DuPuis was a founder of the Lemon City Library in 1902, the Lemon City Methodist Church and the White Belt Methodist Church. He gave many years of active service to the boards of his church. He was a charter member and first president of the Dade County Farm Bureau. Also, he was president of the Board of Supervisors of Little River Valley Drainage District.

In 1916, Dr. DuPuis was responsible for eradicating the Texas tick fever in Dade County, the first county in the state to stave off the inroads of this infectious disease in dairy herds. The following year he helped eliminate tuberculosis among the dairy herds of that county. One of the earliest of his many business projects was the founding of the White Belt Dairies, and later the Klondyke, Roselawn and Alta Terra Dairy Farms. His activities in this field resulted in higher standards of milk supply. In recent years he was cited by the Florida Dairy Industry Association as the oldest dairyman in Florida. He was a past president of the Dutch Belted Cattle Association of America.

His study of pellagra in 1909 established this malady as resulting from a nutritional deficiency. During the epidemic of influenza in 1918, his observations of the nature of this disease and his method of treatment contributed greatly to its control not only in Dade County but throughout the nation. During World War I, he was examining physician in South Florida and chairman of the Board of Conservation and Economics for Dade County.

(Continued on page 604)

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*Schaefer, F. H.: Ohio State M. J. 51:347 (April) 1955.



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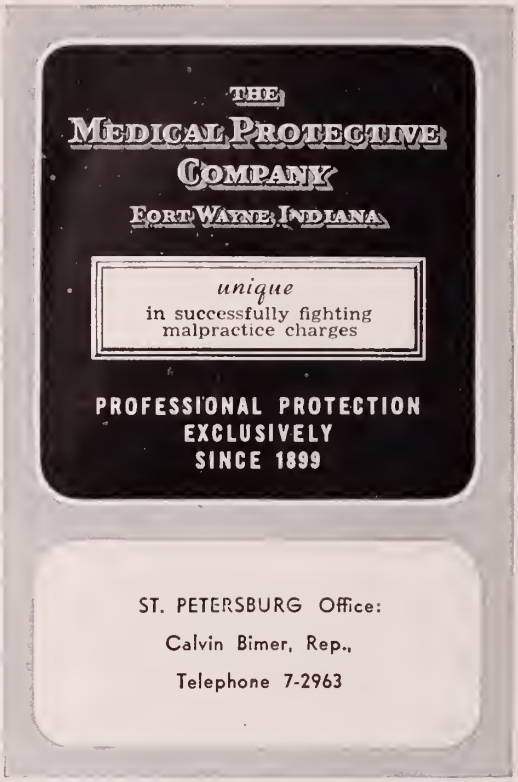
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(Continued from page 600)

Dr. DuPuis was the sole surviving charter member of the Dade County Medical Association and he had served as its president in 1906. Upon the fiftieth anniversary of his service as an active member, this society presented him with a plaque in recognition of his long and faithful participation in its activities since its founding in 1903. A life member of the Florida Medical Association having honorary status at the time of his death, Dr. DuPuis had been a member for 50 years. He also held membership in the American Medical Association, the Southern Medical Association and the Association of American Physicians and Surgeons.

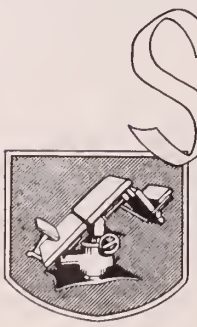
Surviving are the widow, Mrs. Katherine DuPuis, and one son, John G. DuPuis Jr., both of Miami; three sisters, Mrs. Anna D. Futch, of St. Petersburg, Mrs. Gladys Neill, of Atlanta, Ga., and Mrs. Ione Bush, of Fort Lauderdale; one brother, Carlyle DuPuis, of Alachua; and one granddaughter, Mrs. William F. Egan, of Miami.

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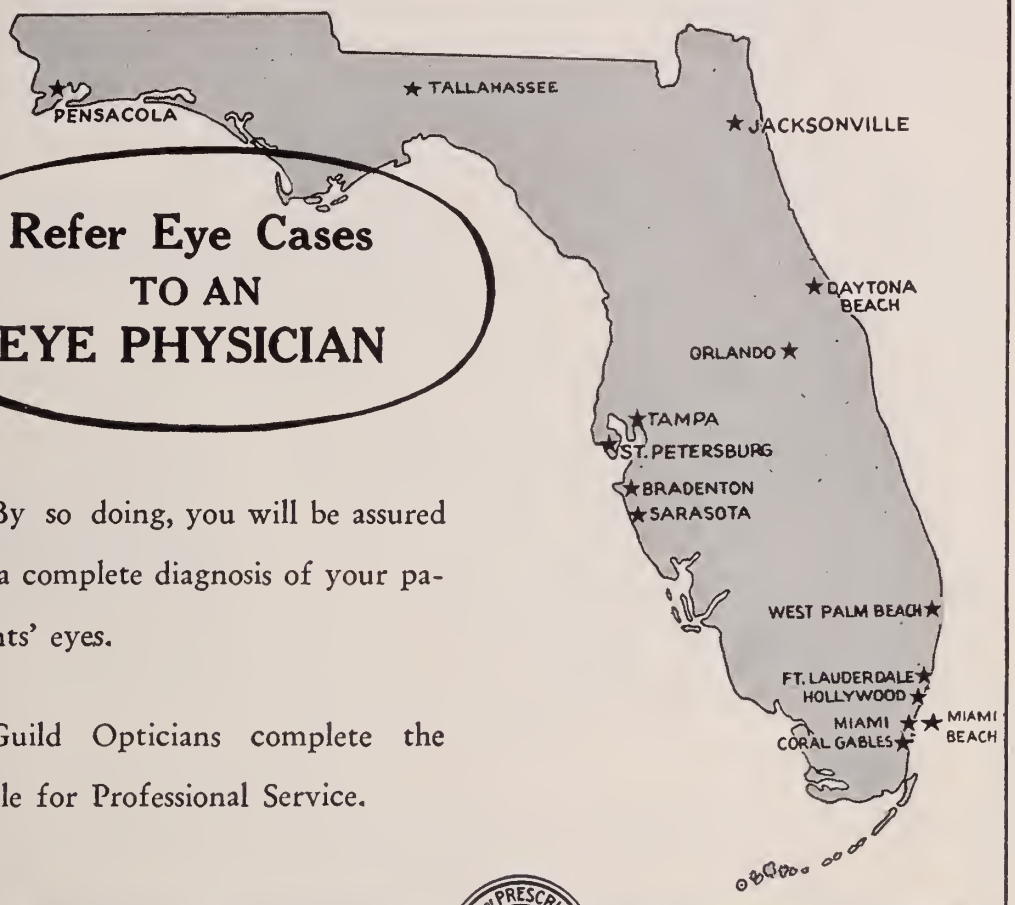
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Auxiliary Programs and Projects Continue to Expand

One of the things those of us who attended the annual fall conference of state presidents, presidents-elect and national committee chairmen learned is that every state auxiliary is busy and all members of the Woman's Auxiliary to the American Medical Association are taking part in the program and projects. The enthusiasm, desire for further knowledge, friendliness, exchange of ideas and opportunity for such exchange was one of the major accomplishments of this conference.

Held at the Drake Hotel, Chicago, on November 1-3, 1955, it came at a time when all of us were looking forward to a new year and were busy consolidating what we had already done and starting new programs and projects as the need was shown for them. Though the committees which are set up for program and project work do not vary much from year to year, the work under them is continually expanding. As one need is met, another is found and the Auxiliary members start meeting it. Add to this conference, the local joint meetings, state meetings in which the Auxiliary participates, regional legislative conferences and A.M.A. conferences on various subjects



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in which the Auxiliary can be of help, such as public relations, legislation, mental health, rural health, safety, AMEF, et cetera, and one can easily see that the Auxiliary is not only active but well informed. Most of these meetings fall between September and the first of December and one can look upon this period as a learning and studying time and the first of January as a time for action. Thus, the first of each year sees your Auxiliary geared up and ready for action.

This past period of gaining information and learning emphasized continued activity in what the Auxiliary is already doing and increased enthusiasm and planned activity in the fields of mental health, rural health and safety. The Mental Health Committee of the Auxiliary is in its third year. Some state auxiliaries have Committees on Rural Health and some do not. Rural health and safety is still as a whole coming to us from the national Auxiliary. However, it looks as if these will become national committees in the next year or two and with the increased need for support, every state will soon follow suit.

The figures for November 4, 1955 show that the Florida Auxiliary is ahead of itself in subscriptions for Todays Health, a magazine that is becoming more and more recognized by our doctors and the lay public as a needed guide and textbook on health.

Florida Auxiliary public relations activities and legislative education activities are well respected by those on the staff of the A.M.A. and also those in other states. Florida is leading the way in some mental health projects and we are sought after in many things we are doing since we seem to be pioneers. The outstanding of these has been the results of exhibits at county, regional and state fairs. Constant requests for material or information on how we did certain projects are being received by the Florida Auxiliary.

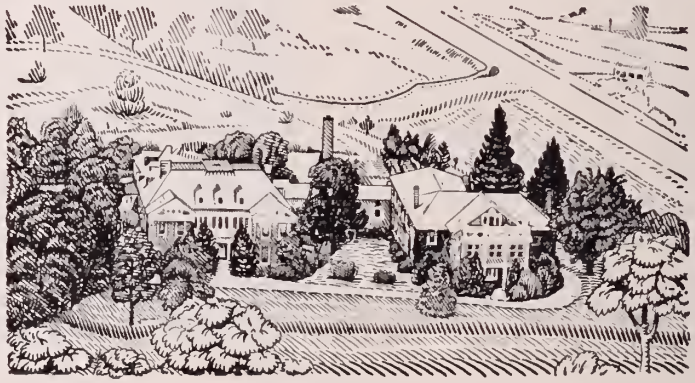
By our increased consolidation and expansion of projects and program, we can be assured that again in 1956, the Florida Auxiliary report will carry with it a record of which we can be proud and things of such interest to others that we will continue to receive requests for material and information from other states.

—Mrs. Richard F. Stover

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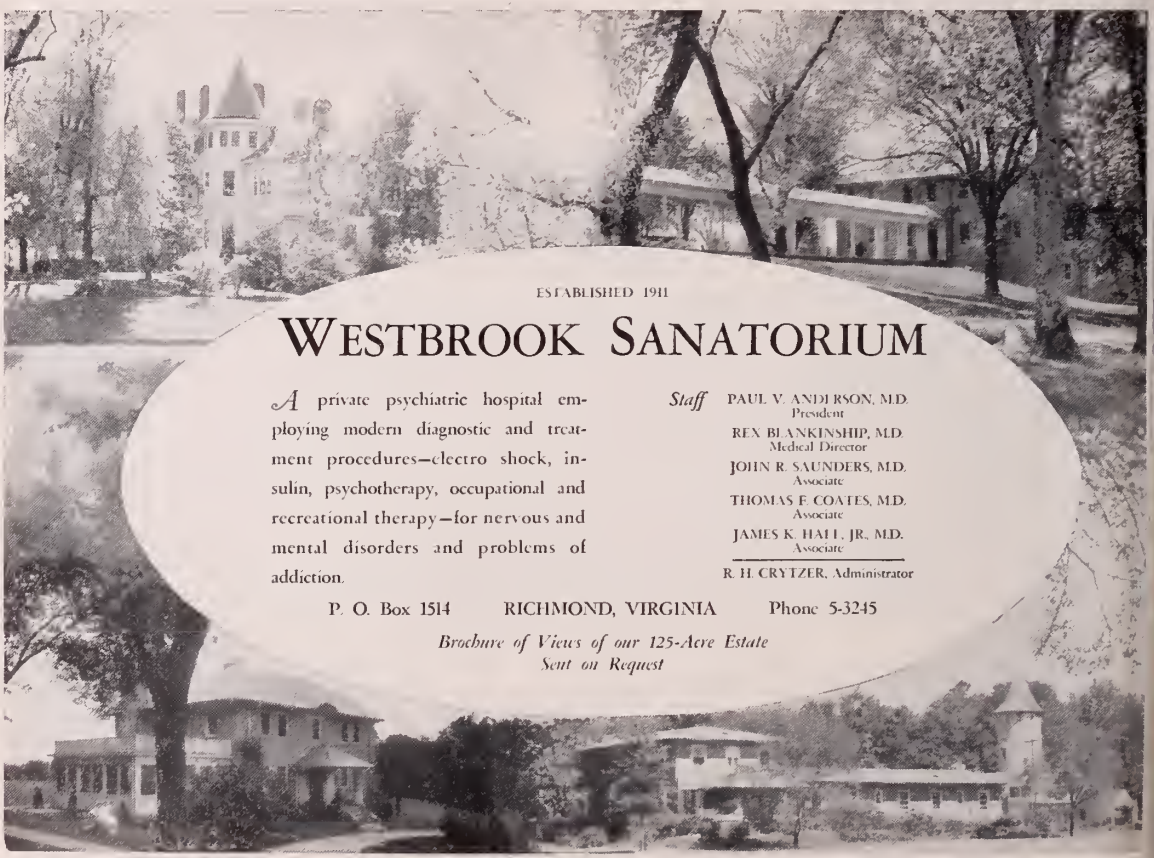
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Northwest	William P. Hixon, Pensacola	Walter J. Baker, Foley	Tallahassee
Northeast	Henry J. Babers Jr., Gainesville	Charles L. Park Sr., Sanford	Ocala
Southwest	C. Frank Chunn, Tampa	James R. Boulware Jr., Lakeland	Tampa
Southeast	James R. Sory, West Palm Beach	Ralph S. Sappenfield, Miami	West Palm Beach
l da Specialty Societies			
Ac emy of General Practice	Frank T. Linz, Tampa	James B. Hodge Jr., Tampa	Miami Beach, May 13, '56
Al gy Society	W. Ambrose McGee, W. P. Bch	Norris M. Beasley, Ft. Lauderdale	" " " "
thesiologists, Soc. of	Wayland T. Coppedge Jr., Jax	John T. Stage, Jacksonville	" " " "
t Phys., Am. Coll., Fla. Chap.	Hawley H. Seiler, Tampa	William L. Potts, Lantana	
e . and Syph., Assn. of	Joseph L. Hundley, Orlando	Kenneth J. Weiler, St. Petersburg	
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hal. & Otol., Soc. of	Charles W. Boyd, Jacksonville	Kenneth S. Whitmer, Miami	
opedic Society	Edward W. Cullipher, Miami	Robert P. Keiser, Coral Gables	" " " "
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tric Society	Wesley S. Nock, Tampa	Henry G. Morton, Sarasota	" " " "
ologic Society	Thomas F. Nelson, Tampa	George Williams Jr., Miami	" " " "
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ons, Am. Coll., Fla. Chapter	Joseph S. Stewart, Miami	C. Frank Chunn, Tampa	" " " "
gical Society	David W. Goddard, Daytona Bch.	W. Dotson Wells, Fort Lauderdale	" " " "
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sic Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Miami, June 9, '56
od Banks, Association	Louis E. Pohlman, Orlando	Mrs. Estelle Lieberman, W. P. Bch.	Pensacola, May 26-27, '56
e Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	
e Shield of Florida, Inc.	Wayland T. Coppedge Jr., Jax	John T. Stage, Jacksonville	Miami Beach, May '56
ncer Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	Miami Beach, May 13, '56
nical Diabetes Assn.	Sidney Davidson, Lake Worth	Edward R. Smith, Jacksonville	
ntal Society, State	T. A. Price, D.D.S., Miami	W. A. Buhner, D.D.S., Daytona Bch.	Miami Beach, May 28-30 '56
art Association	Victor H. Kugel, Miami Beach	Edwin P. Preston, Miami	Miami Beach, May 9-12, '56
spital Association	Mr. Pat N. Groner, Pensacola	Mr. Steve F. McCrimmon, C. Gbls.	
dical Examining Board	Morris B. Seltzer, Daytona Bch.	Homer L. Pearson Jr., Miami	Miami Beach, June 24-26, '56
dical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 25-29, '56
rse Anesthetists, Fla. Assn.	Miss Dorothy Jackson, C. Gables	Mrs. Lulla F. Bryan, Miami	June 24-26, '56
rses Association, State	Martha Wolfe R.N., Coral Gables	Agnes Anderson, R.N., Orlando	Clearwater, May 20-23, '56
rmaceutical Assoc., State	Miss Frances Walpole, Sarasota	Mr. R. Q. Richards, Ft. Myers	
blic Health Association	L. L. Parks, Jacksonville	N. J. Schneider, Jacksonville	Jacksonville, Apr. 12-14, '56
deau Society	Harold W. Johnston, Orlando	Howard M. DuBose, Lakeland	Jacksonville, Apr. 12-14, '56
berculosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mr. Ernest L. Abel, W. Palm Beach	
man's Auxiliary	Mrs. Samuel Lombardo, J'sonville	Mrs. Leffie M. Carlton Jr., Tampa	Miami Beach, May 13-16, '56
mican Medical Association	Elmer Hess, Erie, Pa.	Geo. F. Lull, Chicago	Chicago, June 11-15, '56
M.A. Clinical Session	Elmer Hess, Erie, Pa.	Geo. F. Lull, Chicago	Seattle, Nov. 27-30, '56
ou ern Medical Association	W. Ray. McKenzie, Balti., Md.	Mr. V. O. Foster, Birmingham	Washington, Nov. 12-15, '56
a ma Medical Association	F. L. Chenault, Decatur	Douglas L. Cannon, Montgomery	Birmingham, Apr. 19-21, '56
e ia, Medical Assn. of	H. Dawson Allen Jr., Milledgeville	David Henry Poer, Atlanta	Atlanta, May 13-16, '56
Hospital Conference	Mr. D. O. McClusky Jr. Tuscaloosa, Ala.	Mr. Pat Groner, Pensacola	Miami Beach, Apr. 18-20, '56
ou eastern Allergy Assn.	Ben Miller, Columbia, S. C.	Kath. B. MacInnis, Columbia, S.C.	Charlotte, N. C., Oct. 5-6, '56
ou eastern, Am. Urological Assn.	Sidney Smith, Raleigh, N. C.	Robert F. Sharp, New Orleans	Hollywood, Mar. 25-29, '56
ou eastern Surgical Congress	Donald S. Daniel, Richmond	B. T. Beasley, Atlanta	Richmond, Mar. 12-15, '56
u Coast Clinical Society	E. T. McCafferty, Mobile, Ala.	Theo. Middleton, Mobile, Ala.	

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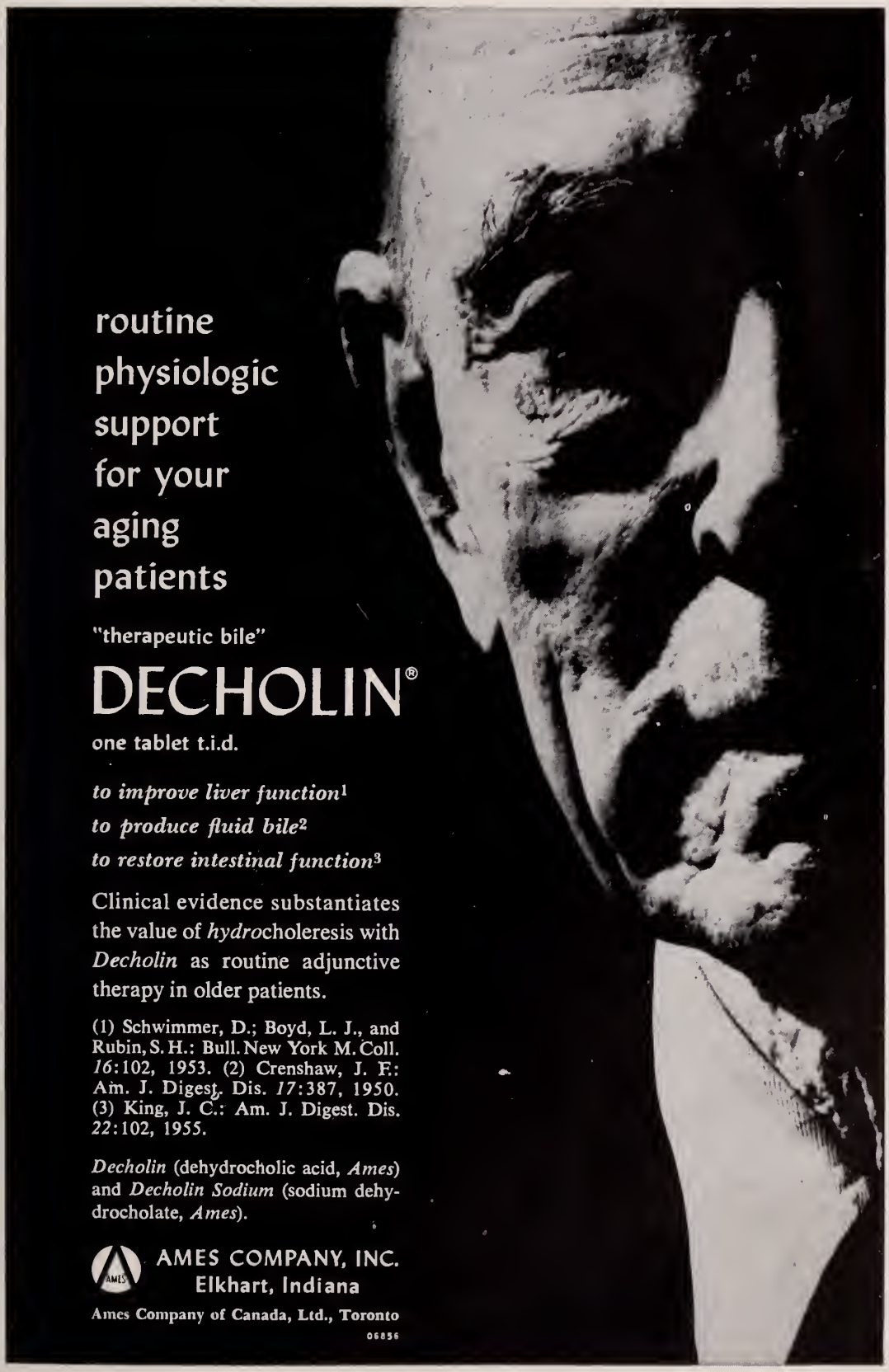
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(1) Schwimmer, D.; Boyd, L. J., and Rubin, S. H.: Bull. New York M. Coll. *16*:102, 1953. (2) Crenshaw, J. F.: Am. J. Digest. Dis. *17*:387, 1950. (3) King, J. C.: Am. J. Digest. Dis. *22*:102, 1955.

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Vol. XLII FEBRUARY, 1956 No. 8

Eighty-Second Annual Meeting
Miami Beach, May 13-16, 1956

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Sidney Davidson and Robert E. Raborn

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Herschel G. Cole and Albert A. Wilson

School Vision Screening Methods
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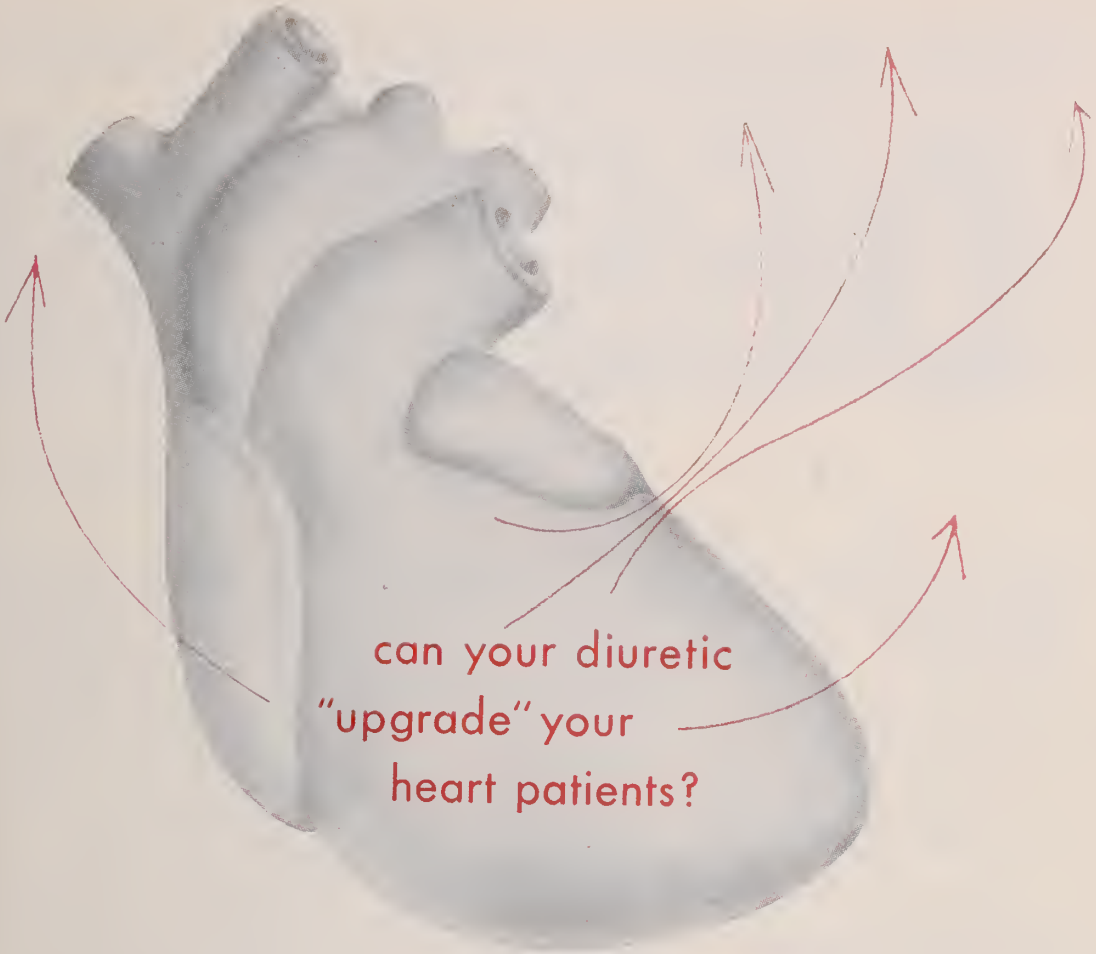
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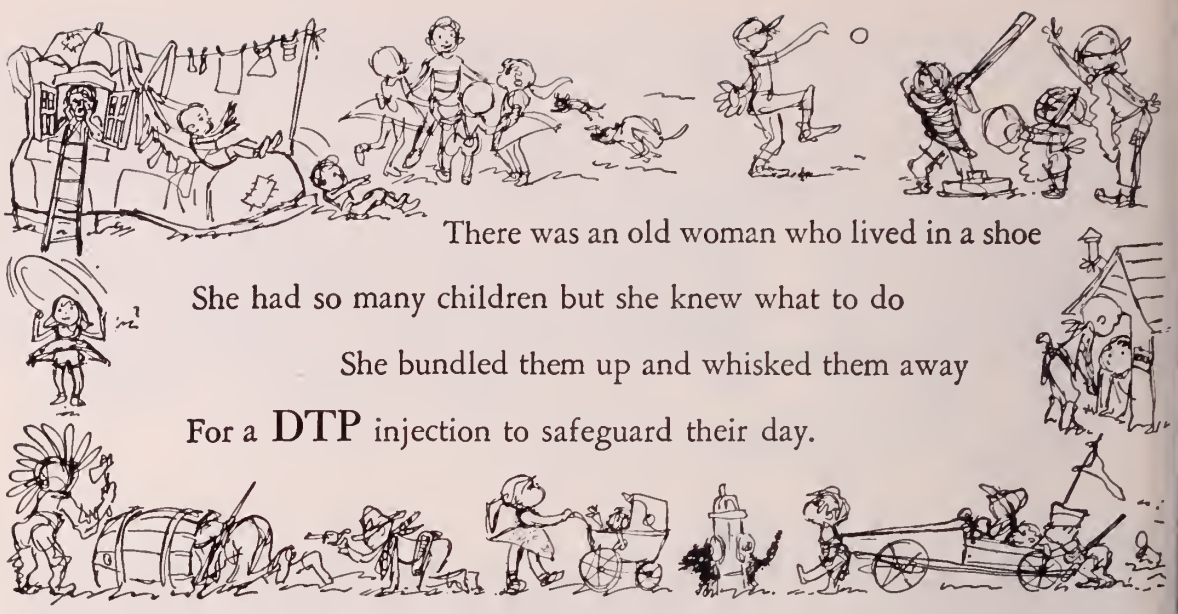
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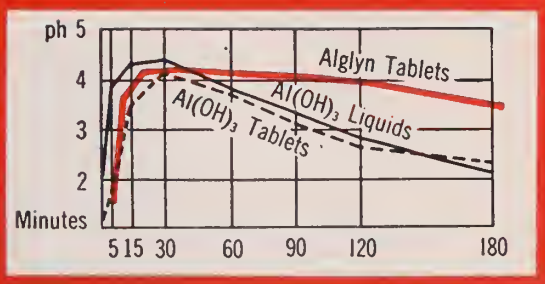
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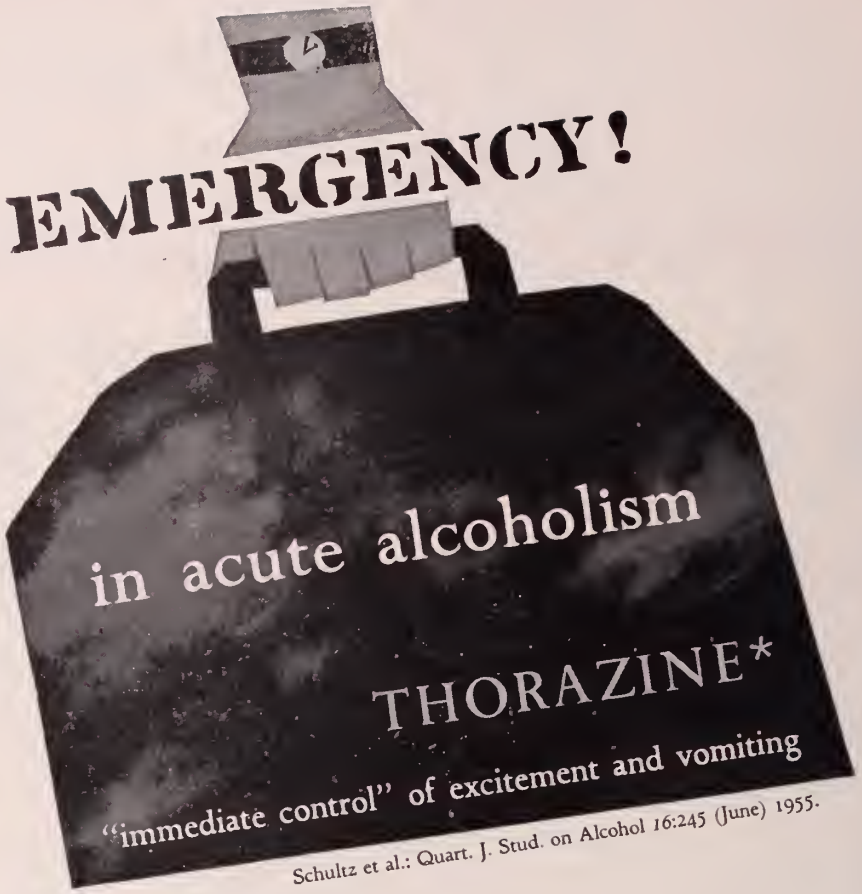
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2. Hammarlund, E.R. and Rising, L.W.: J. Am. Pharm. Assoc., Scientific Edition, 38:586, 1949.

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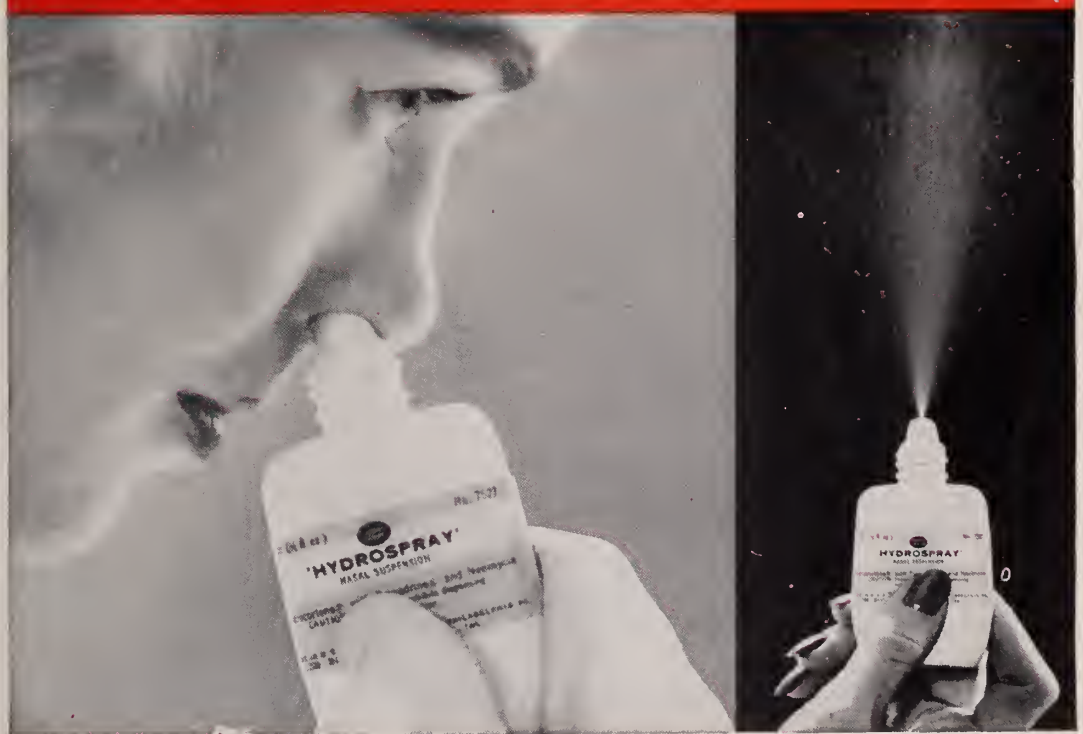
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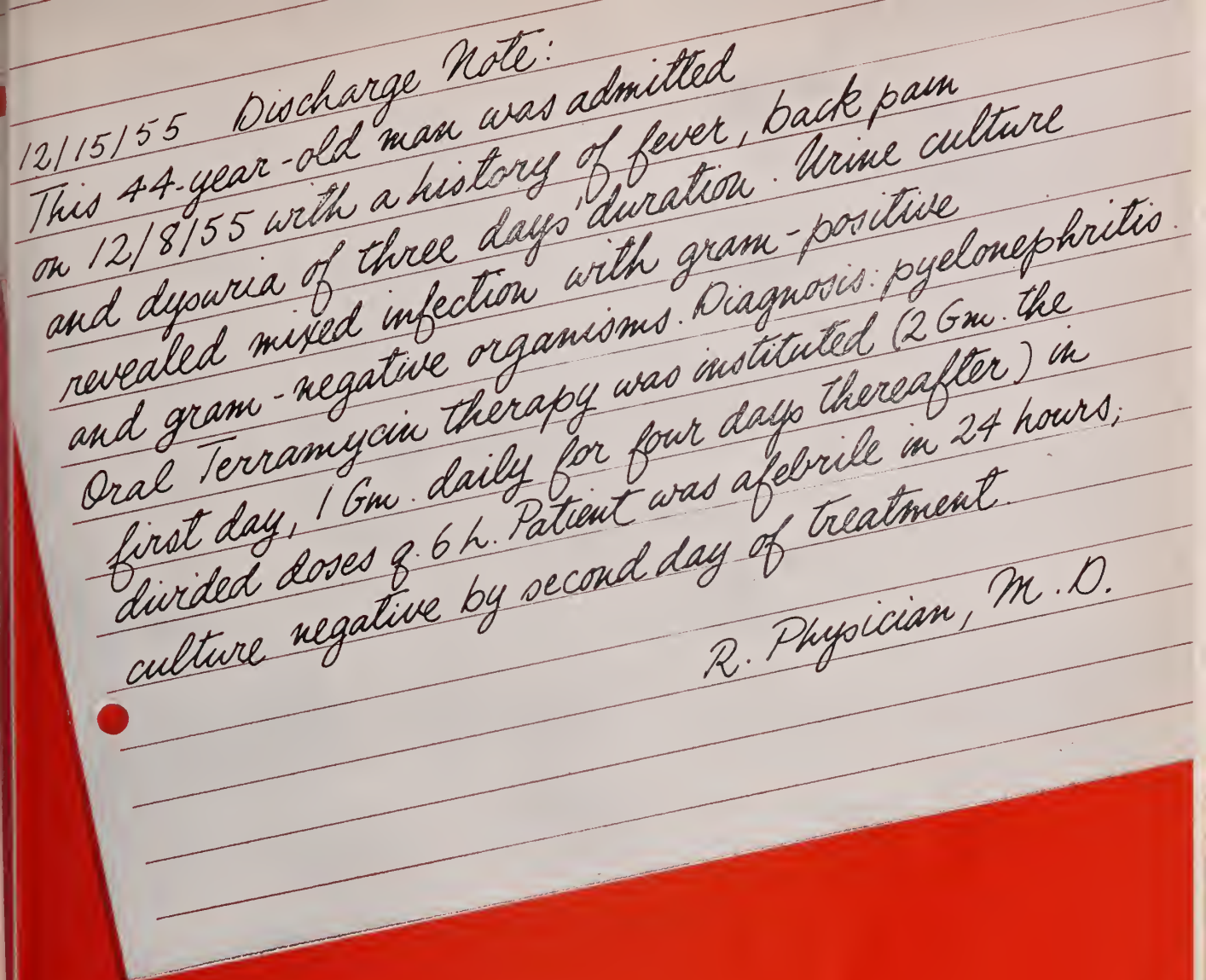
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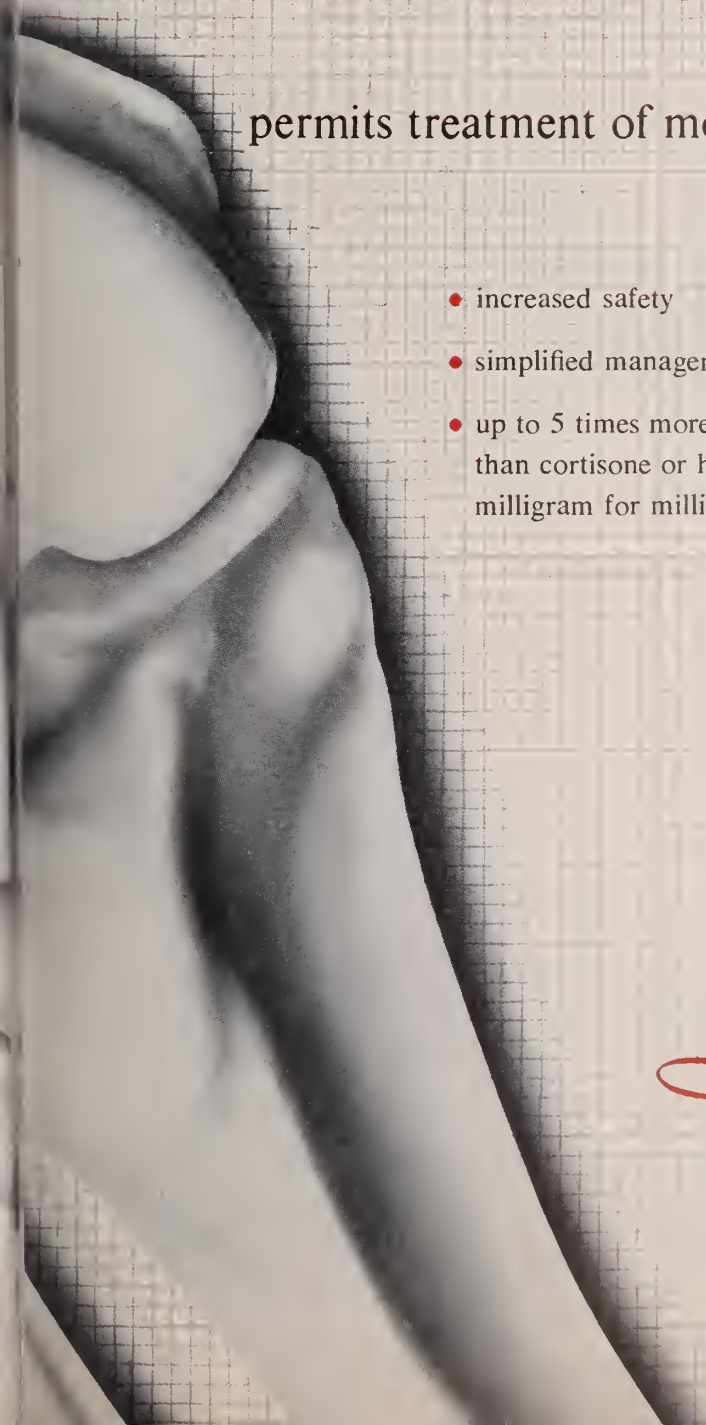
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The Journal of The Florida Medical Association
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Reconstructive Surgery in Children

Clifford C. Snyder, M.D.
MIAMI

Great changes have been observed in surgery during the past 25 years, especially in the field of plastic and reconstructive surgery. Though most of the basic principles of surgery are permanent, technics have improved and emphasis has been placed on physiopathology and biochemistry. The plastic surgeon's acceptance of his failures has led to advances in his therapy, and the follow-up system has improved his competence. The physician who adopts surgical treatment of the infant and child should realize the responsibility, because in his efforts a life may be made or destroyed. He must understand clearly the existing disease, carefully plan his corrective therapy and constructively criticize his results. A variegated group of lesions has been selected, which may be of some particular interest to all. I have purposely omitted burns, hand deformities, malignant lesions of the head and neck, and most phases of cosmetic surgery.

Cleft Lip and Palate

The term harelip is not used in this specialty because it is erroneous. A bunny has a midline upper lip cleft which is rare in the human. Parents are embarrassed when asked about their harelip children, but accept the term cleft lip, and since the anomaly is a facial cleft, it should be described as such. This is a congenital malunion of embryologic parts, which occurs during the first trimester of pregnancy. It is either incomplete or complete and unilateral or bilateral. The etiology is idiopathic, though many theories exist with new concepts being presented frequently. The factor of heredity plays an influencing part. The condition may coexist with a cleft palate. Though the statistics vary, this anomaly occurs approximately once in every thousand births.

The technics of repair are as numerous as are the surgeons who employ them, but all aim to achieve a smooth vermilion border with a cupid's bow and symmetric nasal orifices. The operation is accomplished early to eliminate embarrassment to the parents; therefore, as soon as the infant's metabolic processes are adjusted to its new environment, surgery may be planned. Most plastic surgeons wish to operate during the first two months of life. The bilateral cleft lip is a controversial problem in regard to both when and how to correct the defect. If the premaxilla exhibits an extreme protrusion, it may necessitate severance. The blood supply runs along the edge of the vermilion and may be partially destroyed by attempted closure in one operation. This damage will cause atrophy and shortening of the prolabium. When two operative procedures are utilized to reconstruct the bilateral cleft, there is less scarring, and shortening of the prolabium is minimized.

The cleft in the palate may be complete or incomplete. Anyone may reach the heights of success without good looks, but without good speech few attain such heights. Poorly planned surgical procedures usually terminate with a paralysis of the soft palate due to injury to the nerve supply or to excess scarring. Postoperative oroantral and oronasal fistulas are common when the blood supply is embarrassed or the soft tissues are roughly manipulated. Though a partial cleft involving only the soft palate may appear as a simple surgical problem, in the hands of an inex-

Read before the Florida Medical Association, Eighty-First Annual Meeting, St. Petersburg, April 5, 1955.

perienced surgeon a catastrophe will result, and further surgery or speech therapy will be of no avail.

Blepharoptosis

Ptosis of the upper eyelid is either congenital or acquired and may be unilateral or bilateral. The levator palpebrae muscle may be maldeveloped, or the oculomotor nerve may be injured. The infant does not present symptoms, but as the child grows older, the mother becomes aware that the youngster in order to see must bend the head and wrinkle the forehead. Treatment should be instituted as soon as the diagnosis is definitely established. The type of surgical procedure that is utilized depends on the surgeon's training. Good results have been achieved by various methods. One of these is to use a section of fascia lata as a sling. Its inferior border is sutured to the lower edge of the tarsus and after division of its superior portion into three strips, these are interwoven into the fibers of the frontalis muscle and supported by suturing the ends into the dermis of the forehead. Experience is a necessity to evaluate the amount of lid elevation to accomplish.

Ear Anomalies

The delicate anatomic contour of the normal auricle presents probably the most difficult reconstructive task in plastic surgery and requires multiple tedious procedures. For total auricular reconstruction various materials have been used including autogenous, homologous and heterogenous cartilage, metals, paraffin, rubber, gelatin and others. At the present time one must be satisfied with a fair simulation of the normal ear. When cartilage is used, it is carved, diced or pressed into shape and then implanted in the ear region to resemble the helix, antihelix, and scaphoid fossa. A tubed skin flap, which is devised from the neck, is used to produce a helix. A split thickness skin graft will form the cephaloauricular angle. The protruding ear is the commonest congenital deformity and is caused by an undeveloped antihelix. It may be associated with macrotia, microtia or other miscellaneous abnormalities. To correct the lop ear, the antihelix is reconstructed and the ear then brought closer to the head by removing a section of cartilage as well as integument.

Pigmented Lesions

The nevus or so-called mole may be the size of a pin point or may cover most of the body. The malignant nevus is the melanoma. The consensus is that nevi should be surgically removed and not treated with agents such as roentgen rays, radium, carbon dioxide, and acids or burned with electrical currents. The reason is that the resected lesion can be examined by the pathologist to be sure of its extirpation, and the cosmetic result is excellent. Other methods of therapy may result in stimulation and spread of the lesion, and the cosmetic result is always in question.

Hemangiomas are subject to different classifications, but nearly all of them are benign. In these modern times there are still persons who insist that their children were born with birthmarks because of some delightful or disagreeable impression during the gravid state. Hemangiomas may grow rapidly and destroy an organ such as the eye or invade the brain (Sturge-Weber syndrome) and cause death, but these are not common. Occasionally a hemangioma may become dangerous because of thrombosis or severe hemorrhage.

Management of the condition should be not only to eradicate it but also to achieve a good cosmetic result. External and interstitial irradiation therapy in the hands of a specialist is acceptable, but because 85 per cent of all hemangiomas are apparent by the age of 1 year, bony growth centers should be protected and viable areas guarded. Injection therapy is popular, and such sclerosing agents as sodium morrhuate, boiling water, magnesium sulfate, hypertonic saline and alcohol are used. One of the safest materials is Sotradecol Sodium, which does not produce necrosis and ulceration of the skin; it is not necessary to inject it into any certain blood vessel; instead it may be deposited within the near vicinity. Cautery is probably the oldest existing treatment and it has advanced from the hot soldering iron to the modern expensive machine. This type of treatment usually ends in scarring. Many surgeons attempt to locate and ligate feeders to the lesion, while others apply sutures in the vascular bed and tie them in order to obliterate the cavernous sinuses and small vessels. While all of these therapeutic measures may be applicable to some of the hemangiomas, surgical excision with primary closure or skin graft covering gives excellent results for most of them.

Facial Hemiatrophy

There are two types of this disease, one progressive and the other nonprogressive. Symptoms do not become manifest until after a few months

of life and sometimes not until puberty. The skin, fat, muscle and bone are affected, but usually there is no damage to nerves. The cause, though many theories have been advanced, is still obscure. Regardless of what means is used to correct this condition, one must be sure of strict asepsis because the least infection usually leads to failure. Dermafat grafts have proved satisfactory, but because of atrophy, the graft must be much larger than the desired result. The line of incision is hidden in the hair-bearing region of the scalp.

Treacher Collins Syndrome

This congenital disorder is also known as birdface. It is characterized by a bilateral agenesis of the malar eminences, mandible, and external ears. The patient is usually deaf. There is an absence of eyelashes along the medial aspect of the lower eyelids. The palate is either highly arched or cleft. There may be two rows of teeth present both in the mandible and maxilla. The lateral canthus usually is notched and the upper eyelids arched. The nose appears enlarged because the malar eminences are absent. To correct this group of lesions it is necessary to perform many procedures. The malar protuberances are elevated by dermafat or cartilage grafts. The external ears are reconstructed by cartilage and skin grafts. A cartilage or bone graft will produce the necessary contour for the mandible. Z-plasty will help the canthal notching, and a rhinoplasty will add much to the final cosmetic effect.

Tumors

In children the mixed tumor of the parotid gland is often confused with acute parotitis. Infections are usually painful, are accompanied by a fever, and subside in a few days. Mixed tumors do not disappear, are not tender, and must be treated surgically instead of medically. The early benign tumor usually is encapsulated and can be extirpated without endangering the facial nerve. When the lesion is malignant, it necessitates complete removal, and if the seventh cranial nerve is involved, it should be sacrificed. The resultant facial paralysis can be cosmetically corrected at a later date. Adequate surgical exposure is accomplished by an incision along the auricular tragus, around the lobe and down a flexion crease in the neck. The skin is undersected and elevated medially. The benign tumor is removed by blunt dissection, with any nerves encountered carefully isolated. Cysts and fistulas of the thyroglossal duct occur in the midline of the neck in the region of the hyoid bone. The only successful treatment is to remove the cyst, a portion of the hyoid bone, the fistulous tract and a coned section of the base of the tongue.

Urinary and Anal Incontinence

The nerve supply to both the anal and bladder sphincters originates in the second, third and fourth sacral nerves. Any disease or injury to the source of these nerves may produce an inability to control bowel movements and urinary flow. Such conditions as spina bifida, meningocele or myelomeningocele may be responsible. Any traumatic severance of the nerve supply, including surgical operations, may be the causative agent, and there are also congenital anomalies of each sphincter as such that may be the cause of this distress. During the first few months of age this problem is of no inconvenience to the mother. When the child reaches the age at which he should develop sanitary habits and is still unable to accomplish control of his excreta, both the child and the parents become embarrassed. Though these functions are not a necessity to life, their malfunction leads to social problems, economic distress and mental depression.



Fig. 1.—Cadaver specimen exhibiting six neurovascular bundles supplying gracilis muscle. Anatomic books describe one or two neurovascular bundles, but this is contrary to findings on 110 cadaver lower extremities.

Many operative maneuvers have been presented in order to correct this lesion, including fascial and muscle slings, constriction sutures about the anus, injections into the sphincter area of sclerosing agents in order to produce scar tissue, and transplantation of muscles. The gracilis muscle has been used both as a urinary and anal sphincter imitator. This muscle originates on the pubic bone and inserts on the tibia. It has an abundant blood and nerve supply (fig. 1). Its



Fig. 2.— Gracilis muscle detached from its insertion showing its graceful and long structure.

function to the lower extremity, if lost, will not impede locomotion. As its Latin name implies, it is graceful and long, and therefore is an excellent choice for such a purpose (fig. 2). In dissecting a large number of cadavers, one finds at least 11 muscles that may be used for this purpose, but none as satisfactorily and safely as the gracilis.

This muscle is detached from the tibial insertion and dissected free to its origin on the pubis. The large neurovascular bundle at the proximal end of the muscle belly must be saved (fig. 3). The nerve supply is derived from the obturator, and the blood supply is a branch of the femoral artery. The perineum is exposed, the muscle tendon is interwoven through the soft tissues around the anus, including the levator ani, and anchored to the opposite ischial tuberosity with stainless steel wire (fig. 4). Before the wire suture is positioned, the anal orifice is tested with a gloved finger, pulling the muscle taut and approximating the position to suture the attachment. It is better to make the anal opening too tight than too loose.

If urinary incontinence is also present, the opposite gracilis muscle is used to correct this



Fig. 3.— Large neurovascular bundle being saved near the origin of the muscle.



Fig. 4.— Gracilis muscle tendon being interwoven through soft tissues around the anus.

condition. The bulbocavernosus muscle is exposed, and the muscle and tendon are wrapped around it and the urethra in a barber pole manner in order to distribute the constriction over a wide area (fig. 5). The end of the tendon is then likewise attached to the opposite ischium. Utilization of both gracilis muscles at one operation is a new technic. Approximately 30 of the anal procedures have been performed to date in this country.

Conclusion

The young surgeon of two decades ago was unfortunate in that his meager training resulted in producing many failures, which he was able to correct through his own further experience. Today through intern and residency programs, wise counsel by his already-experienced teachers guides his future. Departments of surgical research are available to work out problems on the lower animal before attempting them in the human. Indeed, progress has been made these past few years, and false theories which have been accepted as textbook facts for many years are now being corrected, and definite facts proved.

550 Brickell Avenue.



Fig. 5.— The opposite gracilis muscle tendon being wrapped around the bulbocavernosus muscle and urethra



Fig. 6. — The patient has good bladder control and has no difficulty with urinary stream.



Fig. 7. — Photograph showing patient after micturating. He was able to start and stop the urinary flow as he desired.

Discussion

Dr. Robert B. Lawson, Miami: I enjoyed Dr. Snyder's paper very much. I am sure that the reason he wanted me to say a few words about it was because so much reconstructive surgery is in children and I believe that it is important to bring out certain features of this subject. He mentioned in particular the child with the adrenal hyperplasia, and that child illustrates the three points I would like to leave with you from the pediatric standpoint.

The first point is that in reconstructive surgery one should be sure of the diagnosis because the diagnosis and a knowledge of the natural history of the lesion will help one to decide what therapy is necessary. For example, a girl can have pseudohermaphrodism due either to tumor of the adrenal or to adrenal hyperplasia from various causes. The therapy is quite different. A child can look much like a female who is actually a male and vice versa.

So also with hemangiomas. There are certain of the hemangiomas that are better left alone since most "strawberry marks" gradually fade after seven or eight months. There are others that it is better to treat by surgery or radiation. What one does will depend on the individual lesion and the age of the child when he is seen. One does not want to commit oneself to the same program for all hemangiomas. If the diagnosis is not definite, the surgeon wants to be sure that he gets other advice to help with the diagnosis and to make a prognosis before operation is decided on.

Secondly, an important pediatric aspect is the need for adequate care for the children during their operative period in the hospital. This is very true of children with burns and of children with any kind of major reconstructive surgery. There was, for example, a time when children were given too much saline, and the surgeons taught the pediatricians to take it easy. Now the point has been reached where frequently the children do not get enough electrolyte and water intoxication results. There needs to be better teamwork here. That is most important. This is particularly true in the treatment of burns. There are all kinds of formulas and rules of nines, and so many millimeters of fluid per kilogram of child times the per cent of burned body surface. Useful as they are, one cannot treat a child with a formula alone.

The third point is that one must not forget the psychogenic situation that is present. Children with cleft lip and the cleft palate — the child with the Treacher Collins syndrome and the child with adrenal hyperplasia — all develop a certain amount of psychogenic difficulty because of their defects. One can do much by correcting the defect surgically. One can do a great deal from the pediatric standpoint by getting the child in good condition for the operation. If one forgets, however, that the scars in the child's mind are often less visible but even more important, one may find oneself with patients who are not satisfactory "people." It is important to remember that during the surgical period and after the surgeon finishes his task, he must carry the child along from the psychologic standpoint to make sure that the child then gets good speech training and good psychogenic support in order to be healthy in all the aspects of his life.



Electrocardiographic Changes in the Intermediate Coronary Syndrome

II. Location of Lesions

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The intermediate coronary syndrome presents a clinical picture of acute coronary artery disease midway between that of angina on the one hand and acute myocardial infarction on the other.[1] Its genesis is prolonged acute coronary insufficiency. It results in moderate myocardial injury, which may be reversible. Pain is usually present, and is distinguishable from angina in that the precipitating factor is not obvious, the duration is longer, and it is not abolished by rest and nitroglycerin. In addition to the pain, there are other evidences of myocardial damage, such as evolutionary changes in the ST segments and T waves, which are usually reversible. QRS changes occur.

In a syndrome such as this, which seems to be so like acute myocardial infarction but of a lesser order of magnitude, one would expect the electrocardiographic changes, although characteristic of a lesser order of severity, to demonstrate involvement of the same area of the heart as in acute infarction. In our investigation of the electrocardiographic abnormalities characteristic of this condition, however, it seemed to us that the distribution of the locations of the lesions was somewhat different from that observed in acute myocardial infarction.[2]

Since acute myocardial infarction is commonly considered to be just a more severe stage than the intermediate syndrome in the process of coronary artery disease, this difference in distribution seemed to be worth investigation. For this reason, we have attempted to localize the lesions in our cases and perhaps come to some conclusion as to whether or not there was any significant difference between localization in this condition and in acute myocardial infarction.

Twenty-two of our cases fitted our criteria for the diagnosis of intermediate coronary syndrome; that is, the patients were admitted to the hospital for an acute episode characterized by pain typical of myocardial ischemia. The other clinical findings were not striking, the course was uneventful, and the electrocardiographic changes were definite but readily reversible. Table 1 shows the incidence of the various patterns in the intermediate syndrome and in 100 consecutive cases of acute myocardial infarction. In the cases of intermediate coronary syndrome in which the location was diagnosed as anteroseptal, the diagnosis was based usually on inversion of the T waves from V2 through V4. Rarely were there ST segment changes. These T wave abnormalities were usually completely reversible at the end of six weeks. In those cases in which the location was diagnosed as anterolateral, there were T wave changes usually in V5, V6, lead I, and AVL, or in V6, lead I, and AVL, or in lead I and AVL alone. In our 1 case of posterior wall involvement, there were ST and T wave changes in AVF, and leads II and III. In 1 case, there were pronounced changes in almost all leads — standard, precordial, and unipolar limb leads. This 1 case was categorized as indeterminate. These changes were not of long duration, but were present throughout. Within three weeks, there was complete reversion of all changes to the normal pattern. There were no QRS abnormalities in any of these cases.

It is obvious (table 1) that the distribution of the various areas of the heart involved seems to be different in the two conditions. In the intermediate coronary syndrome, the anterior wall was involved in 81 per cent of the cases, while in acute myocardial infarction, it was involved in only 42 per cent. On the other hand, in the intermediate coronary syndrome, there was involvement of the posterior wall in only 1 case or approximately 5 per cent, while in acute myocardial infarction it was present in 58 per cent. Although the number of our cases of intermediate coronary syndrome, 22, is too small to be significant statistically, the difference is so pronounced that it must be considered valid.

Discussion

This characteristic of the milder types of acute coronary episodes to involve the anterior surface of the left ventricle rather than the posterior surface has been noted by others. In their report on posterior wall infarctions, Papp and Smith[3] noted that in the milder cases, or, as they called them, "slight myocardial infarctions," the incidence of posterior wall lesions was 22 per cent, while in severe infarction it was 57 per cent.

In their study of subendocardial infarction, Yu and Stewart[4] noted the infrequency with which they were able to find posterior wall lesions.

It is our opinion that this apparent disproportion is a result of two factors. One factor is the difficulty of making an electrocardiographic diagnosis of an ischemic lesion of the posterior wall. The diagnosis of posterior wall lesions has always been difficult, especially in the so-called slight attack type of acute myocardial lesions.[3] Papp and Smith,[3] in their series of posterior wall infarctions, in order to uncover obscure or hidden lesions, were able to make the diagnosis much more frequently by using other technics in addition to the usual electrocardiographic leads; they used leads during deep inspiration, exercise tests, and other activities. Under those conditions, they were able to confirm posterior wall lesions much more frequently. Others, too, have noted the difficulty in making the proper diagnosis of posterior wall lesions. Wolff, Mathur and Richman[5] and Myers, Klein and Hiratzka[6] noted that the diagnosis of posterior wall infarction was difficult and was rather readily missed. This difficulty was encountered especially in lesions that were high up in the basal part of the heart, but even those that were lower down were sometimes missed, depending on the position of the heart. They noted also that, although the localization of lesions in the posterior wall was difficult, even when the lesions were high up in the so-called "silent area" (the posterobasal region), some evidence of myocardial damage was always obtained, and seemed usually to be referable to the lateral wall rather than the posterior wall.[7]

The difficulties inherent in making an electrocardiographic diagnosis of posterior wall infarction are compounded by the fact that such a lesion in the intermediate coronary syndrome is nonpermanent, not transmural. For this reason, the electrocardiographic changes are confined to the RST segments and T waves in leads II, III, and AVF.[8] QRS changes which indicate a more extensive lesion are therefore not present to aid in the diagnosis.

In addition to the fact that the electrocardiographic changes are such as to tend to obscure the posterior wall lesions, those pathologic studies in the intermediate coronary syndrome which have been made appear to show that the anterior wall is much more commonly involved than the posterior wall.

The pathologic lesion in this condition is commonly accepted to be subendocardial necrosis. In their studies of acute coronary insufficiency, Horn, Field, Dack and Master[8] demonstrated that the pathologic lesion consists of a subendocardial lesion composed of areas of necrosis which may be individual disseminated foci or confluent areas.

The reason that the subendocardial region is primarily involved in those situations in which there is a relative deficiency in blood flow in the absence of a definite thrombotic lesion that would result in a definite area of infarction, is explained by the assumption that this area of the myocardium receives the poorest blood supply. The

Table 1. — Incidence of Various Patterns in Intermediate Coronary Syndrome and in Acute Myocardial Infarction

	Intermediate Coronary Syndrome		Acute Myocardial Infarction	
Location	Number of Cases	Per Cent	Number of Cases	Per Cent
Anteroseptal	13	59	24	24
Anterolateral	7	32	8	8
Anterior			10	10
Posterior	1	4	44	44
Posteroseptal			2	2
Posterolateral			12	12
Indeterminate	1	4		
Total	22		100	

blood supply to the left ventricle is derived from main coronary arteries, which course down the epicardial aspect of the ventricles, giving rise to perforating branches at right angles to the main artery. These reach well into the subendocardium, where there are apparently diffuse anastomotic channels.[9] In addition, a gradient of pressure existing at the height of systole between the more superficial and deep layers of the ventricular wall has been demonstrated.[10] The intramural pressure in the depth of the myocardium exceeds that of the aortic pressure, while in the superficial zones it may be equal to or even less than the pressure within the aorta and coronary tree. Accordingly, there is increased pressure against susceptible zones during isometric cardiac contractions. This combination of increased intramural pressure with diminished blood supply probably accounts for the subendocardial ischemic lesions. The preponderance of left ventricular lesions as contrasted to involvement of the right ventricle may be accounted for by the relatively less efficient thebesian circulation in ratio to the proportionately greater muscle mass of the left over that of the right ventricle.

In comparing the myocardial lesions resulting with and without a thrombotic lesion, Miller, Burchell and Edwards[11] noted that anterior and anterolateral lesions were most frequent with nonocclusive lesions. In 49 cases of infarction due to coronary insufficiency, only 22 per cent were posterior lesions (75 per cent were anterior); while in thrombotic lesions, 39 per cent (of 57 cases) were posterior. They suggested that the greater frequency of anterior and anterolateral lesions in the coronary insufficiency group was the result of a greater degree of narrowing of the anterior descending coronary artery as compared with the two other major arteries. In acute occlusions, 89 per cent were transmural, while 11 per cent were subendocardial. In coronary insufficiency, 82 per cent were subendocardial and 18 per cent were transmural.

In an attempt to correlate the electrocardiographic findings and the pathologic studies[8,11] which are applicable to this syndrome, the conclusion naturally arises that the lesion is primarily one of subendocardial ischemia which results in varying amounts of necrosis. The electrocardiographic changes, however, which are most commonly found, namely, T wave inversion, are characteristic of subepicardial ischemia rather than involvement of the subendocardium. Experimentally, the subendocardium seems to be comparatively inert electrocardiographically.[12]

We are forced, therefore, to conclude that in these ischemic episodes, the subendocardium suffers the greatest and most obvious structural damage because of its comparatively poor circulation, but the abnormal T waves seen are probably a result of ischemia of the subepicardium which may be accompanied by little or no structural change.

In conclusion, we suggest that the acute coronary episode in the intermediate coronary syndrome is due to an acute ischemic process. The comparatively high incidence of involvement of the anterior wall of the left ventricle is due to more frequent arteriosclerotic involvement with narrowing of the vessels supplying that area. In the comparatively better supplied posterior wall, a thrombotic lesion is a more likely cause of myocardial damage. Under those circumstances, the lesion will usually be transmural and the electrocardiographic changes characteristic.

Summary

A series of 22 cases of the intermediate coronary syndrome is presented, and the localization of the lesions is tabulated. The pronounced difference in localization of the lesions in this condition and in acute infarction is pointed out, and suggestions are made as to the reason for this disparity.

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An Adjunct in the Office Treatment of the Low Back Syndrome

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Low back pain with or without radiation to the leg is now believed due to derangement of the intervertebral disk in as high as 90 per cent of cases. In many of these cases objective findings are not sufficient to require surgery, but the patients are so restricted in activity that they are not industrially employable.

In the past we have treated these patients conservatively — rest on a firm bed, postural training, lumbosacral support, heat, and analgesics. In some resistant cases, admission to the hospital for continuous traction to the lower extremities is advised. We also employ the use of flexion body jackets.

During the past several months, we have instituted a method of intermittent traction therapy, given on an outpatient basis in the office, which has proved beneficial to patients who continued to be disabled after other conservative measures had failed to provide relief of symptoms. Because this method is inexpensive, we think the attention of physicians who treat this type case should be directed to it.

The apparatus consists of a wooden examining table with a cross bar on one end which can be elevated to various settings (fig. 1). Attached to this cross bar are two clamps which fit the shoe much as roller skate clamps. These two clamps are then joined by a spreader bar, which is also adjustable (fig. 2). We ask the patient to lie on a diathermy pad, and we also precede the treatment with a 1.0 cc. injection of Tubadil.

Thus far, treatments have been given daily for a 10 day period, the duration of the treatment



Figure 1

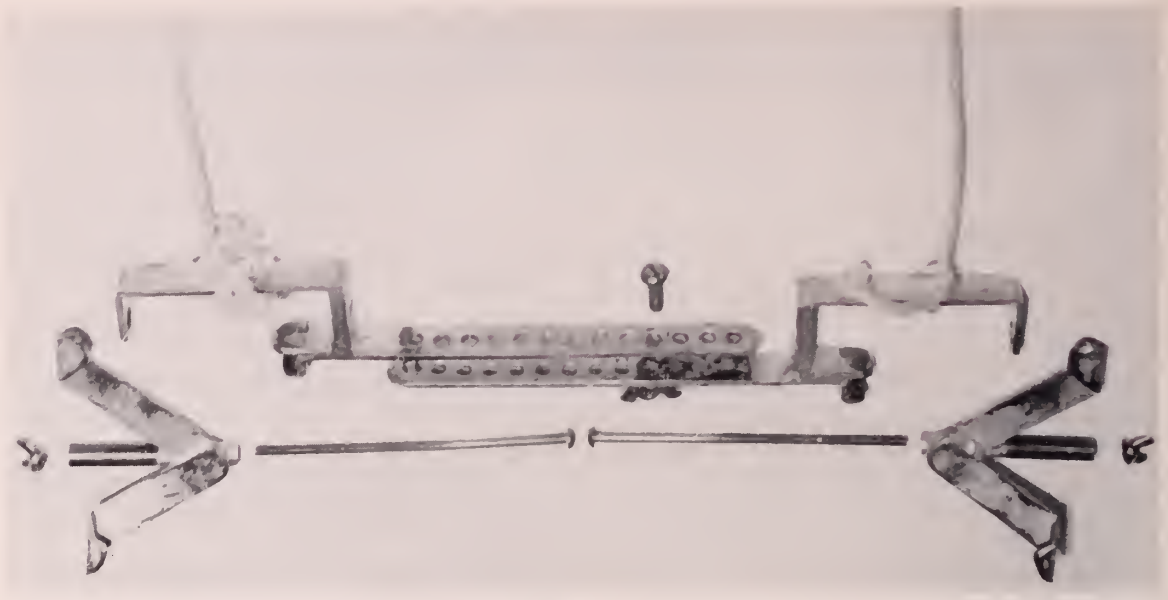


Figure 2

being 30 minutes. On an empiric basis, we apply 20 pounds of weight to the affected leg and 10 pounds to the asymptomatic side (fig. 3).

On a preliminary basis alone, we believe that this therapy may offer certain patients relief who would otherwise continue with a significant degree of disability due to continued low back symptoms. We present the following cases:

Report of Cases

Case 1. — A 40 year old white man, previously healthy, was injured while lifting a deep freeze in November 1954. Roentgenograms of the low back area revealed a diminished lumbosacral interspace with transverse lumbosacral facets and a minimal spina bifida of the first sacral vertebra. The patient was placed at absolute bed rest, was given codeine for relief of pain, and after approximately two weeks was fitted with a lumbosacral support. He continued to complain of a great degree of pain when attempting any type of industrial activity. Because of the persistence of symptoms, it was recommended that he have an exploration for a ruptured disk and a combined spinal fusion.

Fearing surgery, the patient requested treatment from our Clinic. On initial examination, there was tenderness directly over the lumbosacral joint and over the right lumbosacral facet area, the right greater sciatic notch and the right upper sciatic nerve trunk. Neurologic examination revealed some depression of the right ankle jerk with no sensory defect noted and no atrophy by measurement. There was limitation of the right straight leg raising test to 75 degrees. He was given intermittent office traction treatments daily for 10 days, supplemented by the injection of Tubadil and the application of diathermy to the painful area, and was sufficiently relieved of his symptoms so that he returned to work on Jan. 2, 1955. At the present time he is working as a truck driver. He still prefers, however, to wear his lumbosacral support while on duty.

Case 2. — A 32 year old white man was injured on Dec. 7, 1954, as a result of an automobile accident. He immediately sustained a rather severe low back sprain and on the following day was examined and had his back taped by a local physician. He continued to experience pain in the low back area so that a rather prolonged course of diathermy was instituted. Following approximately 20 treatments he was unimproved and continued to experience a moderate degree of pain in the low back area with some reference into the right hip and thigh. There was some limitation of straight leg raising.

The patient was given daily traction treatments for 10 days, supplemented by the injection of Tubadil and diathermy treatments. He was so much improved following this regimen that he was able to return to part time duty as a truck driver.

Case 3. — A 27 year old, heavy-set, white man was struck by a low-hanging wire, throwing him to the ground. He experienced pain in the low back area and had his back taped for three days, but was allergic to



Figure 3

adhesive and this was removed. After approximately six weeks of conservative therapy elsewhere, including chiropractic manipulation, he continued to experience pain with forward bending and occasional radiation of pain into the right leg. There was tenderness to direct pressure over the right sciatic nerve trunk, and there was slight limitation of straight leg raising on the right side. The patient was given a series of 10 traction treatments in the office, supplemented by Tubadil and diathermy and was able to return to work approximately three months after the injury.

Conclusion

It appears, on the basis of these cases and the few other unpublished cases, that intermittent office traction with an inexpensive traction device, combined with Tubadil injections and diathermy, may offer a significant measure of relief in patients with a low back syndrome and an irritative type of sciatic pain.

The apparatus which we use was constructed for us by the Florida Brace Company of Tampa. 1102 West Cass Street.

An Evaluation of Methods in School Vision Screening

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In January of this year, the ophthalmologists of Florida were given a significant opportunity and a challenge by the State Board of Health. We were asked to express our opinion about visual screening surveys in Florida schools. Our society, through its officers, seized this opportunity and responded to the challenge. A report was prepared and presented to the county health officers at their state meeting in Jacksonville in February. Our officers believed that the conclusions of this report should be presented to the entire membership, and therefore it is being analyzed for you here today.

The sought-for goal in visual screening of school children is a simple test that has a high percentage of accuracy in detecting eye defects and a low percentage of unnecessary referrals. The value of keeping false referrals to a minimum is obvious. This factor has caused the near breakdown of visual school testing programs in several places throughout the country. Nothing makes parents more unhappy than the feeling that they have been forced to spend money needlessly.

In a recently completed survey of the ophthalmologists of Florida, it was found that all of the tests now being used have a tendency to refer too many children, the figures being estimated at 20 per cent over-referrals for the Snellen test, 33 per cent for the Massachusetts test and 41 per cent for the Telebinocular test.

In 1952 Crane, Scobee, Foote and Green published a report on procedures in screening surveys.[1] A team of ophthalmologists gave complete examinations to 1,215 St. Louis school children; then a series of screening tests was given to these same children. Included in the study were the Snellen test for distance and near, the Massachusetts Vision Test, the Keystone Telebinocular Test, the American Optical Sight-Screener Test, the Bausch and Lomb Ortho-Rater Test, and teacher observation for symptoms.

None of these tests detected more than 80 per cent of the significant abnormalities, and in general the tests which detected the highest percentage of children who needed referral also gave the highest percentage of needless referrals. The Sight-Screener, Ortho-Rater and Telebinocular tests referred between 54 per cent and 71 per cent of all the children tested as contrasted with the ophthalmologists' failure rate of 27 per cent. The incorrect referrals from these instruments outnumbered the correct referrals by 20 per cent to 250 per cent. The investigators also found that these tests required six times as long to administer as the Snellen chart test. As a result of this study the National Society for the Prevention of Blindness now recommends, as a fundamental screening procedure, the use of the Snellen chart plus teacher observation for signs and symptoms of eye trouble.

Florida Tests

Now, let us consider the situation as it applies to the school children of the state of Florida:

Read before the Florida Society of Ophthalmology and Otolaryngology, Sixteenth Annual Meeting, St. Petersburg, April 3, 1955.

Throughout Florida there are at least three different types of visual screening examinations currently being conducted in the schools. The most widely used test is the Snellen chart for visual acuity with the use of either variously positioned E's or the alphabet letters. Another test gaining wide popularity is the Keystone Telebinocular. The third test is the Massachusetts Vision Test.

There are three aspects of ocular function measured by these tests, namely, visual acuity, hyperopia and muscle balance. The Massachusetts test measures all three, the Telebinocular test measures visual acuity, muscle balance and indirectly hyperopia, and the Snellen Chart measures only the visual acuity. Now, let us analyze the different aspects of the tests.

1. Visual Acuity
 a. Snellen E Chart

 In the St. Louis survey study there was an average failure rate of 18.2 per cent in the Snellen test with 20/20 used as passing.[1]

 In Broward county this past year, the Snellen chart test was given to 12,800 students in grades 1 through 6. With 20/20 standard for all grades, there was an average failure rate of 19 per cent, and there was no significant difference at any given grade level. There was, however, an interesting deviation in some of the schools. In one school of nearly 500 students only 2 per cent failed the test, whereas in another school of the same size, 42 per cent of the children failed. This difference points up the need for standardization of test conditions so as to obtain more uniform results.

 In a survey of 4,000 grade school children in Oak Park, Ill., 85 per cent of the children referred to an eye specialist because of failure on the visual acuity test were given correction in the form of glasses or other treatments.[2] In Broward County 75 per cent of the children coming to my office after failing the Snellen E school survey test needed glasses and another 10 per cent had an eye condition that required further observation.

 The St. Louis group found the Snellen chart plus teacher observation gave a 70 per cent correct referral rate. There is, therefore, about an 80 per cent accuracy of the referral failures of the Snellen E visual acuity test, and this results in only 20 per cent of needless or excessive referrals.

 b. Massachusetts Vision Test

 The visual acuity portion of the Massachusetts test consists of the 20/30 and the 20/20 lines of the Snellen E chart. For children in grades 1 through 3, 20/30 is passing and for the older children 20/20. In a survey study of 2,200 children in De Kalb County, Georgia, the failure rate for this part of the test was 6.9 per cent.[3] When the children who failed this test were retested by an ophthalmologist, 77 per cent failed again. These figures indicate, therefore, a 23 per cent excess referral rate. Most of the children who were false failures were in the first and second grades.

 c. Telebinocular Test

 The visual acuity portion of the Telebinocular test utilizes black dots of diminishing size. The average failure rate is higher than with the other tests.

 In an optometric survey in Kansas the failure rate for this part of the Keystone test averaged 29 per cent.[4] Of the children coming to my office with a record of failing the vision part of the Telebinocular test, only 60 per cent were found to need glasses or other eye care. This result indicates a seriously high rate of unnecessary referrals.

2. Hyperopia
 a. The Massachusetts vision test includes a type of examination for hyperopia. A pair of glasses containing a +1.50 diopter sphere is worn by the child, and he is asked to read the 20/30 line. If he can do so, or in other words, if the glasses do not blur his vision, a circumstance that occurs only if the child is hyperopic, he is graded as having failed that part of the test.

 In the Georgia survey with this test, the failure rate was 9.7 per cent.[3] When these children were re-examined by an ophthalmologist, it was found that only 22 per cent of them needed glasses or eye care. The false failure rate of 78 per cent was alarmingly high. An improvement in this test was made by the Illinois group by

using +2.00 diopter lenses for the older children and +2.50 diopter lenses for the younger ones.[2] The failure rate thereafter decreased from 11 per cent down to 1.5 per cent. A most interesting follow-up study then was conducted. Most, in fact 74 per cent, of the children who failed the test were doing better than average work in school. Hyperopia, in itself, is not a condition that needs correcting by glasses unless it is accompanied by evidence of poor reading, headaches and muscle imbalance. This test, however, may not be entirely without merit, as will be indicated later on.

b. The Telebinocular test for hyperopia is the measurement of visual acuity at the near point. A hyperopic child may see clearly at a distance, but have blurred vision at near. While this is theoretically possible, in actual practice children of school age have such a magnitude of accommodation that it is extremely rare for one to fail the near vision test after passing the distance vision test. This part of the test is, therefore, of almost no value in the screening program.

c. Snellen Test
Children with excessive hyperopia or hyperopic astigmatism often will have diminished visual acuity and if so, they will fail the screening test on this basis.

3. Muscle Balance

a. The Massachusetts test has a part that tests muscle balance at near and distance which is given to those children who have passed the first two parts. The failure rate in the Georgia survey was 1.8 per cent.[3] Re-examination, however, revealed that 40 per cent of the failures were false.

b. In the Illinois survey a type of muscle test was used that is similar to the Massachusetts test except that it is made at only intermediate distance.[2] The failure rate was 1.2 per cent. Again in this group, only 60 per cent of the failures were later given glasses or treatments.

c. The Telebinocular test includes elaborate tests of muscle balance, and failures are given for relatively smaller degrees of imbalance than in the two previous tests. In a survey of 200,000 students in Kansas given the Telebinocular test, a lateral imbalance at the far point was found in 6 per cent, and at near in 12 per cent, and a vertical imbalance in 1.5 per cent.[4] These figures are several times higher than those for the other tests because of the rigid standards used. The allowable deviation at far is 1¾$^{\Delta}$ esophoria to 3¼$^{\Delta}$ exophoria and at near 2.8$^{\Delta}$ esophoria to 4.7$^{\Delta}$ exophoria. In a study of the Keystone lateral muscle balance tests made by two optometrists in Yonkers, N. Y., it was found that the normal distribution curve of lateral phorias covered almost the entire extent of the instrument test range and covered an area more than twice as wide as the accepted doubtful area and six times as wide as the accepted normal area, both for distance and near.[5] In my office in Broward County, I found that from the Keystone muscle balance tests 85 per cent of the referred children had a muscle balance considered as normal by our present medical standards. The Telebinocular muscle tests seem entirely too difficult and critical for school children.

d. Snellen test. A number of the school children with a significant imbalance of the ocular muscles will have decreased visual acuity in one eye and will, therefore, fail the screening test on this basis.

The test for eye muscle balance can be evaluated also by considering the problem of strabismus from another angle. Of all the children under treatment for esotropia in my orthoptics department, the strabismus in 96 per cent had developed and they had been brought to a doctor before school age. Only in those with exotropia and divergence excess (23 per cent of the total) did the condition develop after the age of 6, and even then it was usually discovered by the parents. Only 10 per cent of the Florida ophthalmologists reported that more than a few strabismus patients had been discovered by a school screening test, according to the recent poll.

Summary

The single most important test that can be used for visual screening is the Snellen vision chart. About 75 to 80 per cent of all eye defects that need attention are detected by this single test.[6] The incidence of over-referrals is no more than 20 per cent. It was recommended by representatives of the Florida Society of Ophthalmol-

ogy and Otolaryngology that this test be given as follows:

1. For first and second grade children. The Snellen E chart should be used. The 20/30 line should be considered as passing.
2. For grades 3 through 8, 20/20 is considered passing.
3. The chart should be supplied with standard illumination that is independent of the general room lighting.
4. Adequate preparation of the younger children for the test is essential.
5. The test should be given to each child a minimum of every other year. This repetition of the test is necessary because the condition that accounts for the vast majority of failures is myopia with or without astigmatism. Myopia usually first becomes apparent between the ages of 6 and 9 and tends to get worse gradually in adolescent years.
6. The test should be given by a person experienced or properly instructed in visual screening testing.

The hyperopia test is of limited value. The condition of hyperopia is normal for a youngster's eyes, is at its maximum at age 6, and diminishes gradually thereafter. We believe that there is some merit in using the test on the second grade children only. We recommend +2.50 diopter lenses and consider 20/30 vision through the glasses as failure. If hyperopia is not excessive at that age, it never will be at any time in the school years. Of the children who fail this test, only those who are behind in their work or complain of their eyes should be referred to an eye specialist. Of course the children who have hyperopia test is very important in school surveys ready have failed the visual acuity test and will be referred on that basis. Forty-two per cent of the Florida ophthalmologists believe that a hyperopia test is most important in school surveys and 58 per cent that it is not highly important.

In a recent correlation between refractive errors and reading achievement, Eames[7] found that of the good readers, 62 per cent had a refractive error (75 per cent hyperopia and 25 per cent myopia) and of the poor readers 84 per cent had a refractive error (85 per cent hyperopia and 15 per cent myopia). Hyperopia, therefore, seems to be a greater handicap to a poor reader than myopia.

The muscle tests of the currently used visual screening instruments are too time-consuming and too unreliable to justify the expense and time required for their administration. The serious muscle imbalances nearly always manifest themselves before school age and are nearly always accompanied by decreased vision in one eye so that they will be detected on the visual acuity test anyway. As has been pointed out by Tait[8] in his Textbook of Refraction, the lateral muscle balance in normally progressing, ocularly comfortable school children may vary from 4$^{\Delta}$ esophoria to 5$^{\Delta}$ exophoria for distance and from 12$^{\Delta}$ esophoria to 24$^{\Delta}$ exophoria at near. It is impossible to set some arbitrary figure as being indicative of abnormal lateral muscle balance. Whether or not any given phoria finding will be related to ocular discomfort depends upon that individual's fusional amplitude.

Thirty per cent of the Florida ophthalmologists replied that they thought some sort of muscle balance test is important in school survey work, whereas 70 per cent believed it of little importance. We have not as yet recommended any particular muscle test for Florida schools. One out of every 67 school children has some type of muscle imbalance, but only 35 per cent of the defective ones register any complaints. It seems likely that a nearly foolproof test like the Atlantic City muscle test[6] or a fusion test such as the Worth 4-Dots might be suitable. For those counties using the Massachusetts test, we recommend that the near phoria test be omitted.

Let us stop at this point to consider two rather philosophic questions. Why are surveys of school children necessary, and why do we want visual surveys? Visual surveys are necessary only because the parents of today will not assume the responsibility of periodic eye examinations for their children. We want such surveys because as a result of these tests we are able to help some children progress more satisfactorily in school and thereby assist the entire group to function with greater efficiency. We could, of course, accomplish the same objective with no tests at all by merely referring every below average student for a complete eye examination.

It is also interesting to consider the result of a survey of the correlation between visual skills and school achievement made in Virginia.[9] Four hundred and sixty-eight seventh grade children were given a machine type of eye test and divided into two groups, passing and failing. In the passing group 56 per cent of the pupils were above

average and 44 per cent below. In the failing group 47 per cent were above average, and 53 per cent were below; the total difference between the two groups was only 9 per cent. Certainly the future of the entire school system would not be in great jeopardy if survey tests were all stopped tomorrow, but on the other hand, all of us believe that they have an important place and we would like to see them improved. In fact, 97 per cent of the Florida ophthalmologists would urge standardization of the screening tests throughout the state.

If we are ever to achieve a nearly ideal program for the children, the responsibilities of the parents, the Public Health Departments and ourselves as ophthalmologists must be understood and met.

Parents should have their children's eyes examined by an ophthalmologist before the children enter the public school system. The parents are responsible for carrying out any recommended follow-up from a school vision survey.

The Public Health Department in cooperation with the school systems is obligated to provide and to supervise a regularly repeated satisfactory visual screening program in the schools. The Public Health Department should ask for and follow out recommendations made to it by the ophthalmologists concerning the types and conduct of its tests. The Public Health Department should not make any contracts with special interest groups in this work, and where such working arrangements are already in existence, they immediately should be dissolved.

We ophthalmologists are obligated to provide complete and accurate eye examinations for our young patients. An examination is not complete without muscle tests and ophthalmoscopy through dilated pupils.

We are further duty bound to offer our advice and even our active assistance to the Health Departments and schools when we are approached for such help. We owe it to ourselves and our profession not to sit idly by and watch other groups more aggressive than ourselves usurp this vital field of eye care.

Lastly, we should support the morale of parents whose children fail a school screening test, but are found to have normal eyes. These parents either will resent the school survey for causing them the expense of a needless referral, or with our help they can be made to feel glad that their child's eyes are normal and that the Public Health Department was interested enough to have conducted a survey. The parents' reaction depends entirely upon the ophthalmologist's explanation of the situation to them.[10] A little diplomacy at the right time goes a long way.

Addendum

At the meeting of the Florida Society of Ophthalmology and Otolaryngology in St. Petersburg on April 3, 1955, the following school screening test was recommended:

1. Illuminated Snellen E chart, either alone or as part of the Massachusetts equipment or Atlantic City test box
 a. Grades 1-2: 20/30 standard
 b. Grades 3-8: 20/20 standard
2. Hyperopia test made on all second grade children with + 2.50 diopter lenses: 20/30 standard
3. Either of two muscle tests
 a. Atlantic City test — distance only
 b. Massachusetts test — distance only

It was further recommended that all Telebinocular tests be discontinued in school screening survey work.

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Discussion

Dr. Marion W. Hester, Lakeland: An interesting visual screening test has just been described by Samuel Diskan in the March issue of the American Journal of Ophthalmology. He calls it the Atlantic City Eye Test. It is much like the Massachusetts Vision Test, but seems to incorporate an improvement. Like the Massachusetts test, it uses illuminated Snellen charts for visual acuity, and plus 1.75 D lenses to uncover excessive manifest hypermetropia. For testing muscle balance, instead of a Maddox rod, it uses a red dot of light inside a rectangle of green light with red and green glasses on the child. The subject has to say only that the red light is inside the green rectangle for normal muscle balance, or outside for abnormal muscle balance.

We in Polk County have used Snellen charts nonilluminated and illuminated, the Massachusetts Vision Test, the Telebinocular Test, and the Ortho-Rater Test. School tests have been sponsored usually by the local Lions Clubs under ophthalmologic supervision. The actual testing has been done by members of Lions Clubs Auxiliaries, school teachers, and school nurses.

Lions Clubs presidents and committee chairmen can generate just as much enthusiasm as their treasuries will allow. A few years ago another ophthalmologist and I were asked to meet with a Lions Club committee in an advisory capacity. They proposed to buy a large mobile eye examination room housed in a large truck which was to be equipped with all necessary instruments and equipment to perform complete eye examinations on school children. The cost of this project was to have been between $3,000 and $4,000. On our advice they bought Massachusetts Vision Test equipment instead, and all parties concerned have been happy with the results.

In setting up a school visual screening program one has a choice of the Snellen chart, the Massachusetts Vision Test, the Atlantic City Eye Test, the Telebinocular, the Ortho-Rater, the Sight-Screener and other tests. A number of surveys of different screening procedures are in the current and recent literature to give reliable guidance in supervising adequate visual screening tests. All are agreed that the screening method should include a test of visual acuity. There is a lesser degree of affirmative opinion for including a test for hypermetropia and another for muscle imbalance.

The points in favor of the tests such as the Massachusetts Vision Test or the Atlantic City Eye Test are that they are relatively inexpensive, simple to use, require less time in testing, and uncover a high percentage of visual defects with a minimum of over-referrals.

The objections to the mechanical devices such as the Telebinocular, the Ortho-Rater, and the Sight-Screener are that they are expensive, are harder to use, require more testing time and seem to cause more needless referrals.

DR. KENNETH S. WHITMER, Miami: I have enjoyed Dr. Benton's paper very much. It is a timely discussion since most of us who are in contact with great numbers of school children are faced with this problem daily.

A year or so ago in Dade County, our local society appointed some of its members to work with a committee composed of members of the school system, interested optometrists, ophthalmologists and members of the Public Health Department. Some members on this committee favored the battery tests, such as the Keystone binocular, whereas the ophthalmologists were inclined to favor more simple and less time-consuming screening tests, such as the Snellen test. The outcome of these meetings was a screening procedure which went into effect last fall in Dade County. It consists of the following:

The vision testing is done by the schoolroom teacher, and the illiterate E chart is used in the first two grades and the Snellen chart after that. If the child fails the E chart or the Snellen chart, then the vision is rechecked by a school nurse who is more familiar with vision tests than possibly the teacher. If the vision in any grade is found to be 20/40 or less in the worst eye, then that child is referred to an eye specialist. Referrals are also made on a basis of teacher-nurse observation, which Dr. Benton stresses in his paper as being so important.

Children who have signs or symptoms such as redness or rubbing of the eyes and frequent stys are usually referred regardless of their vision. Those children who have no signs nor symptoms and whose vision is good, but who are still poor readers in the second or third grade, are then usually referred by the school nurse or teacher to a reading diagnostician. He uses a battery of tests for the different visual skills, and he finds difficulties in 50 per cent of the children who are poor readers. These he refers to an optometrist or ophthalmologist for further treatment.

Other researchers around the country feel that only about 15 per cent of reading disabilities are purely ocular in origin.

In Dade County the Telebinocular, Sight-Screener and other battery tests are utilized.

It is my personal opinion that these instruments have no place in visual screening in the first three grades. It has been my experience that when a teacher encounters a poor reader, she will usually find that this child will fail on some screening test and find it necessary to refer him for further examination. It is only human nature for the teacher to be looking for something to blame for that particular child's inability to learn to read. I find that fewer unnecessary referrals are made by the school nurse.

I do not agree entirely with Dr. Benton's thoughts on hyperopia. I believe that uncorrected hyperopia in school children might play an essential part in their slowness in reading, and think that a test for hyperopia is certainly not time-consuming and might be important, especially since testing for hyperopia has been included in the screening tests in many of the large communities in the country.

I agree that the simplest method is probably the best, but with other groups shooting at all types of tests, I think that we should not set our mark too low, and that we should continue to keep an open mind about all the possible approaches to this study.

82nd Annual Meeting

Florida Medical Association

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ABSTRACTS

Anticoagulants in Coronary Heart Disease. By E. Sterling Nichol, M.D., F.A.C.P., William C. Phillips, M.D., Valentine E. Jenkins, M.D. M. Clin. North America 38:399-412 (March) 1954.

The results of a continuing study of anticoagulant therapy for coronary atherosclerosis are presented. The authors found anticoagulants of value in the following phases of coronary artery atherosclerosis: (1) impending myocardial infarction and acute coronary insufficiency, (2) acute transmural myocardial infarction, and (3) following recovery from either of the foregoing situations, for long term prevention of recurrent attacks. Results of this treatment are reported in 177 patients suffering from impending myocardial infarction and acute coronary insufficiency, 207 patients experiencing 216 attacks of acute myocardial infarction, and 295 patients with coronary atherosclerosis given anticoagulants for periods ranging from three months to over seven years.

In addition to a discussion of the clinical application of the various anticoagulant drugs, a review of their comparative pharmacology is presented. The various complications encountered and their management also are discussed.

Food Allergies: Diagnosis and Treatment. By Lydia Allen DeVilbiss, M.D. Clin. Med. 2:593-596 (June) 1955.

Food allergies can result in the most serious manifestations and complications of medical and surgical problems. They can simulate the customary reactions of other types of allergies, and coexist with them.

Allergies due to foods may not be suspected because of the masked symptoms of allergy. They also may be difficult to cure, for cure depends upon continued patient cooperation over a period of months for children and years for adults.

The original Leukopenic Index was time-consuming and complicated, but the principle is correct. A simplified form of WBC tests for allergies to specific foods has been found accurate and dependable over a period of years. Two illustrative cases are presented. Nonlaboratory tests and treatment are reviewed; the use of drugs is symptomatic.

The Clinical Evaluation of Congenital Cardiac Lesions. By H. Milton Rogers, M.D., Transactions of American College of Cardiology 4:224-228, 1954.

The clinician evaluating any given case of congenital cardiac disease must consider whether the lesion may or may not be amenable to surgery. This presentation is concerned with the typical clinical manifestations of the congenital cardiac anomalies that are amenable to surgery. These anomalies are patent ductus arteriosus, coarctation of the aorta (proximal and distal to the ductus arteriosus), vascular rings, isolated pulmonic stenosis, atrial septal defect, tricuspid atresia and the tetralogy of Fallot, all of which, with the exception of atrial septal defect and isolated pulmonic stenosis, may be diagnosed in the typical case by clinical means. The clinical methods available include history taking, physical examination, electrocardiography and roentgenographic examination of the thorax.

In his discussion, the author demonstrates that those congenital cardiac anomalies that receive benefit from surgery may be diagnosed in most instances by standard clinical means. He urges the pediatrician and the internist seeing a patient with congenital cardiac disease or a congenital anomaly of the great vessels to give first consideration to whether the anomaly may be corrected or ameliorated by surgery.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 1018, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

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Therapeutics — For Whom?

Primum non nocere is a dictum that should be engraved on every physician's writing hand the day he enters the practice of medicine. It is a maxim that should always be foremost in the physician's thought before he reaches for his prescription pad. Unfortunately, the scores of miracle drugs and panaceas that the prolific pharmacal companies bring forth each year give proof to the evanescence of most of their products and convincing evidence that a capsule has not as yet replaced a physician's task of proper thought.

Any physician would be hard pressed to name 50 drugs which he would really consider essential — yet an attempt to count the preparations listed in the Physicians' Desk Reference would be a formidable task. Why then the schism? Why then does the average physician, trained in a good medical school which gives him a firm and thorough education in therapeutics, suddenly become a voluminous writer of prescriptions containing medicines of unproved value, yet whose side effects may be worse than the presenting symptom complex he is treating? Why then does he write a prescription calling for a preparation most likely to have a shotgun effect even when he is certain that only one of the medicaments in the preparation is essential for a cure? It would indeed be a revelation to any physician to make a carbon copy of each and every prescription he writes in one day and at the end of that day to read them over and reassess the ones he honestly believed were going to benefit the patient solely by the therapeutic effect of the drug or drugs given.

One may rationalize that the public still identifies the physician with the herb healer of old and therefore expects a prescription for each complaint. It is true that many patients are unhappy unless they get a shot of B_{12} or $B_{56.5}$, or at least a pretty pink pill. So the physician accommodatingly acquiesces to the patient's demand, but, by so doing, he loses his role as a physician and becomes a drug dispenser.

The busy physician — often too busy to take refresher courses in medicine and unable to wade through the maze of articles in a jungle of medical journals —is bombarded daily by advertisements of drug firms and detail men always

offering something newer, something with an added drug in it, or just something. To this bombardment is added the pestering of his patient who has just read of a new drug in his favorite magazine. Again, the physician betrays his role and once again becomes a dispenser by using these preparations before they have been properly evaluated.

Perhaps if one considers the field of antibiotics, the answer to the problem is almost found. Volumes have been written on the promiscuous use of antibiotics telling of their dangerous and disabling side effects, of the increasing bacterial resistance to them and of their possible sensitizing effects. On the other hand, the number of reactions and sensitizations is probably infinitely less than the number of persons in whom there would develop pneumonia, rheumatic fever, nephritis and other disease which may be the aftermath of a seemingly innocuous respiratory tract infection had not these drugs been used. It is likewise true that those who most strongly condemn the use of an antibiotic in any disease for which it is not specific, ofttimes use it for "prophylactic measures." In other words, all physicians use antibiotics when not specifically indicated because of their fear that if they do not use them, a worse disease or complication may develop.

It becomes evident then that the physician in many cases in which he offers a medication is not treating the patient as much as he is treating his own anxieties. There is the anxiety lest he disappoint a patient by not giving him a prescription; the anxiety lest he not be one of the first to use a new panacea, the anxiety that his diagnosis is not too accurate and that a shotgun preparation or antibiotic is better than a period of close observation. He further substitutes prescriptions because of the anxiety caused by his failure to realize that the limitations of present day medical knowledge are no fault of his own.

Recently, several excellent articles have appeared on the use of placebos. No one can doubt their value in selected cases. But let not the physician delude himself into believing that the average prescription he writes merely acts as a placebo. Let the physician realize that many of his prescriptions are not drugs for the patient, but are in reality a placebo for his own anxiety. In most cases, he is prescribing a potent drug, one which may change the clinical picture so as to delay an accurate diagnosis, one which may have side effects worse than the disease itself. All these dangers, however, are infinitesimal compared to the danger of the physician prostituting his knowledge and profession in order to allay his own anxieties. Therapeutics? Certainly. They are the basis of good medicine. But therapeutics for whom?

Florida Poll of Physicians on Social Security Coverage

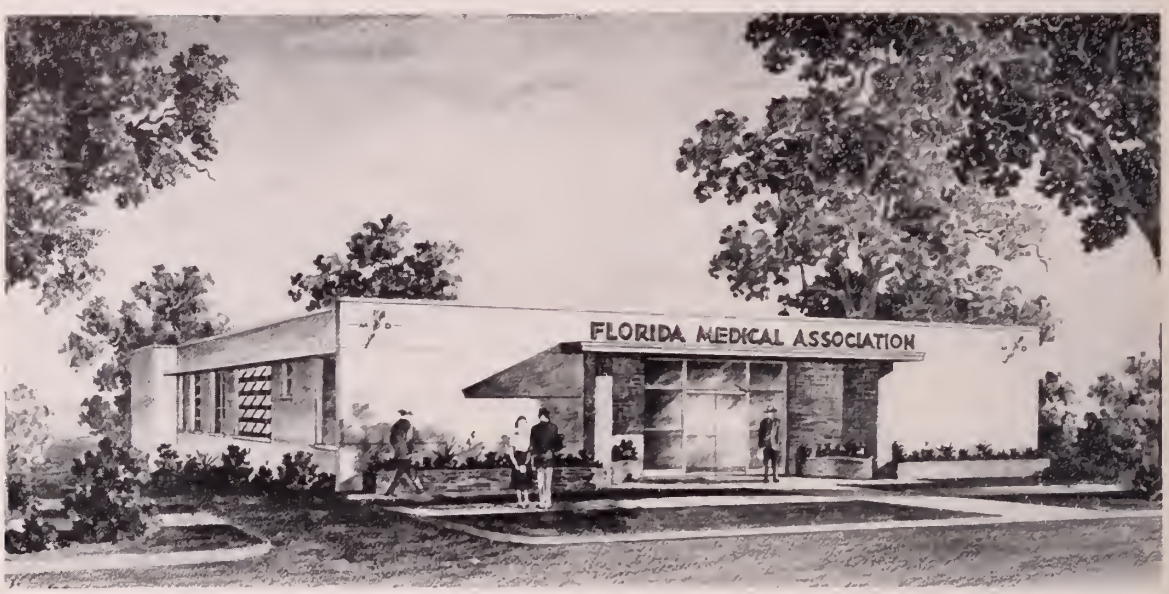
To clear up misunderstanding about the position of the medical profession on the question of inclusion of physicians in the Old Age and Survivors Insurance provisions of the Social Security Act, the House of Delegates of the American Medical Association at the recent Boston meeting recommended to state medical societies that they poll their entire membership. The societies were urged to transmit the results of the poll to the Board of Trustees of that organization as soon as possible.

The members of the Florida Medical Association have already been polled on the matter. A letter explaining the proposal was sent to each member in 1954 with the request that he return the attached post card indicating thereon his desire.

There were 1,585 replies to the 2,330 letters mailed out, a 68 per cent return. Tabulation of these replies showed that 279 favored inclusion of physicians in the coverage, 282 would desire coverage if the limit of $75 a month maximum earnings to receive benefits were substantially raised or eliminated, and 1,020 did not desire to be included. Thus, only 17.6 per cent of the members who replied desired to be included, 17.7 per cent favored coverage only on broader terms, and 64.3 per cent were opposed to inclusion.

The results of this survey indicate clearly the position of the Association. "It is the opinion of the Association," said Dr. H. Phillip Hampton, Chairman of the Committee on Legislation and Public Policy, "that if social security is extended to cover physicians, it should be optional and not compulsory."

The results of similar polls throughout the nation will be of particular interest just at this time both to physicians and national legislators. This proposal and various other aspects of social security legislation currently pending in the Congress are of vital importance to physicians and should command their closest attention.



The first home to be owned by the Florida Medical Association, shown here in the architect's drawing, is now under construction in Jacksonville. The single story structure is of masonry construction, completely fireproof, and of contemporary design. Strategically located on Riverside Avenue, adjacent to the Expressway which distributes traffic in and out of the city, the new headquarters is readily accessible. It is anticipated that it will be ready for occupancy this summer.

Association's Permanent Home

The phenomenal growth and expansion of the Florida Medical Association in recent years have made the need for adequate quarters pressing. Recognizing the urgency of the situation, the Board of Governors in 1954 directed that a study be made to determine the extent of the need and how to meet it. Dr. John D. Milton, then President-elect of the Association, served as chairman of the investigating committee. The other members of the committee were Drs. William C. Roberts, Norval M. Marr, Louis M. Orr and Samuel M. Day.

The obvious handicaps of the cramped quarters now in use and the economy of owning rather than renting under present rental conditions, as established by an engineering survey, led the committee to recommend to the Board that the Association build suitable executive offices. The Board, in turn, made recommendations to the House of Delegates that such a project be undertaken and that the building be located in Jacksonville. The House approved these recommendations at the annual meeting in St. Petersburg in April 1955.

Dr. Milton, who acceded to the presidency of the Association at that meeting, appointed a Committee on Permanent Quarters, composed of Dr. Edward Jelks, Chairman, and Drs. Samuel M. Day and Robert B. McIver. This committee acted promptly to expedite the project.

An ideal site was purchased at reasonable cost, and such rapid progress was made that the plans for the Association's first home of its own were accepted, ground was broken, and construction was under way before 1955 had waned. In mid-1956 the Association, now in its eighty-second year, should at long last be at home in permanent quarters at 735 Riverside Avenue in Jacksonville.

Public Attitude on Medical Care Costs

The belief that the cost of medical care is much too high apparently is not as prevalent as it may seem to be. A report of a national survey of opinions and attitudes toward medical care just released to the pharmaceutical industry by the Health Information Foundation of New York indicates that 40 per cent of the adult population believe food costs are much too high; 45 per cent believe repair charges, such as for television and automobile repair, are excessive; 27 per cent are equally critical of clothing costs, and only 26 per cent believe that the cost of medical care is much too high.

That medical costs in general come in for less criticism than other elements of the cost of living is gratifying. In the category of medical costs it is noteworthy, however, that those who believe costs "much too high" for doctors' fees represent 16 per cent; for hospital charges, 39 per cent; for dentists' fees, 24 per cent; and for prescriptions at drug stores, 38 per cent.

When asked to cite what makes it easier to have good health today than it was 30 years ago, 71 per cent mention improvement in medical knowledge and facilities, and 47 per cent, or almost half the population, specifically refer to new drugs, medicines, and vaccines now available. Nevertheless, 56 per cent of the population cannot give the name of one company which, they believe, manufactures a new or "wonder drug."

Only 11 per cent of the respondents give specific credit to the drug companies, pharmaceutical houses, the chemical industry, or drug manufacturers for these "wonder" drugs. An additional 9 per cent mention "laboratories," and 23 per cent credit doctors, the American Medical Association, or groups of doctors. Forty per cent, however, credit scientists, science, research, or persons such as medical researchers and chemists.

With regard to prescriptions, 38 per cent of the population believe their cost is much too high, and 28 per cent believe the cost is somewhat more than it should be. Less than half of those giving reasons for the high cost in this category attach blame to anyone. Of those complaining of prescription costs, 26 per cent blame the druggists, 10 per cent mention physicians, and 7 per cent name the pharmaceutical manufacturers. An additional 16 per cent blame an unspecified "they." Some mention more than one person or group.

The more the physician takes cognizance of the public attitude regarding the cost of medical care the better he will get on with his patients, and the greater service he will be able to render them and the profession by meeting the issue squarely. Mutual understanding regarding costs promotes good feeling and strengthens the doctor-patient relationship.

Lone General Practitioner Scores a First

The general practitioner of medicine commands the respect and admiration of a grateful populace to whose ills he is a willing slave. Nevertheless, his ability to cope with any emergency, his versatility and his courage are too often taken for granted, and so it is that a special word of appreciation is always in order.

Dr. Fred M. Langson, a general practitioner of Nome, Alaska, recently received deserved acclaim for a unique accomplishment. Dr. Langson is the medical director and only physician on the staff of the Maynard MacDougall Memorial Hospital in that far northern American outpost. This 25 bed institution was given full accreditation last fall by the Joint Commission on Accreditation of Hospitals. Although the Joint Commission surveys 1,500 hospitals every year and some 4,000 over a three year period, never before has it approved a hospital directed and operated by only one physician.

The commission director, Dr. Kenneth B. Babcock, found the hospital to be "in excellent maintenance and condition, and clean and sanitary throughout, with a cheerful, friendly atmosphere pervading the entire institution. . . The charts containing histories, physicals, and laboratory reports are excellent, and would do credit to any teaching hospital." Dr. Langson often holds consultations with members of a United States Air Force hospital which is located nearby. Staff members of the Air Force hospital fly into Nome to be of assistance at specific times. All roentgenograms and tissues for pathologic study are sent to Seattle, and the reports are sent back air mail.

Commenting on the fact that this is the first one man hospital ever accredited by the commission, Dr. Babcock declared it "a wonderful example of a fine job being done by a dedicated general practitioner." The institution is run by the Women's Division of Christian Service of the

Board of Missions of the Methodist Church.

Congratulations and best wishes, Dr. Langson, as you carry on in medicine's best tradition.

Hospital Service for the Indigent

An editorial on the subject of hospital service for the indigent appeared in The Journal under this same heading in the December 1955 issue. Tentative rules and regulations for this program have been approved by the Hospital Service for the Indigent Advisory Committee, appointed for the purpose of advising the Florida State Board of Health, which administers this program. The committee consists of H. Phillip Hampton. M.D., Tampa, chairman, Edward Jelks, M.D., Jacksonville, Mr. Pat Groner, Pensacola, Mr. Richard Simpson, Monticello, and Mr. Frank Kelly, Miami. The program was placed in operation in a few counties on Jan. 1, 1956.

The regulations establish a formula for the allotment of state-appropriated funds to the counties, the procedure by which a county may initiate its participation in the program, criteria for approval of participating hospitals, criteria for determining medical indigency, the steps in the processing of an application for hospitalization, and other detailed information.

Copies of the regulations have been distributed to the County Health Departments and to the Florida Hospital Association for distribution to its member hospitals. They also are available to any physician through his County Health Department.

One section of the Regulation concerns itself entirely with the criteria for determining need for hospitalization. It is believed that every physician in the state will be interested in knowing what types of patients may be hospitalized under this program. For this reason, Section 6 of the Regulation is given verbatim:

Section 6 — Criteria for Determining Need for Hospitalization

SEC. 6.1 — A practicing doctor of medicine shall determine the need for hospitalization of each patient receiving hospital care under this program. In making his determination the referring physician should recommend for hospitalization only those patients who, in his professional opinion,

1. are acutely ill or injured,
2. are suffering from an illness or injury for which hospitalization is essential to the successful treatment of the patient,
3. are suffering from an illness or injury that can be helped markedly by treatment in a hospital.

SEC. 6.2 — In making these determinations the physician should keep in mind both the objectives and the limitations of this program.

It is the objective of this program to provide essential hospitalization to only those medically indigent persons who are *acutely ill* or injured and who can be *helped markedly* by hospitalization. It is not the intent of this program to provide hospital care for patients suffering from chronic, permanently disabling illnesses or terminal illnesses.

It is recognized that hospitalization is not essential to the treatment of all acutely ill or injured patients; those who can be treated at home should not be recommended for hospitalization. Under no condition should patients be hospitalized for convenience. Because the funds available for hospitalization under this program are limited, the referring physician's recommendation for hospitalization must be made on a comparative basis — thus insuring hospital care for those patients who may be reasonably expected to show the greatest response from a short period of intensive treatment in a hospital.

SEC. 6.3 — Under the provisions of this program hospitalization may not be authorized for patients suffering from mental illnesses, tuberculosis, blindness, or other illnesses or deformities for which provisions for hospitalization are provided by State Mental Hospitals, State Tuberculosis Hospitals, the Florida Council for the Blind, the Vocational Rehabilitation Division of the State Department of Education, the Crippled Childrens Commission or other established State programs.

SEC. 6.4—The referring physician must also bear in mind that it is his responsibility to make the first general determination as to the medical indigency of the patient. He should recommend for hospitalization under this program only those patients, who, in his opinion as a physician and as a citizen, are medically indigent.

SEC. 6.5 — The referring physician in recommending a patient for hospitalization should inform the County Health Department of the medical, surgical or specialized hospital care that the patient will need and recommend the hospital where these services may best be provided. However, after the patient is admitted to the hospital the staff physician to whom the patient is assigned shall be totally responsible for determining the patient's medical needs and directing the treatment of the patient.

Joint Blood Council Formed

The need for a permanent national organization to coordinate activities within given limits has been recognized since before World War II by groups interested in the collection, processing, preservation and use of blood, and in blood research. Their objective has been to insure that an adequate supply of blood and blood derivatives will be available at all times for civilian and military use, under emergency as well as peacetime conditions, and that the blood will be obtained, maintained and dispensed in a safe, orderly, efficient and equitable manner. The newly formed Joint Blood Council now promises fulfilment of this goal.

The Council, which established headquarters in Washington on Nov. 1, 1955, is a completely voluntary group, formed by five national associations. The organizations joining in this cooperative endeavor are the American Association of Blood Banks, the American National Red Cross, the American Medical Association, the American

Hospital Association, and the American Society of Clinical Pathologists. The policies of the council will be determined by a board of directors comprising two representatives from each of the five constituent organizations. Participating on a voluntary basis, the organizations may withdraw from the program upon due notice, and provision is made for admitting additional organizations. The Council itself will not engage in the procuring, the processing or the distribution of blood, or in direct research. It will function only through member associations and organizations.

The president of the council is Dr. Leonard W. Larson, of Bismarck, N. D., a member of the Board of Trustees of the American Medical Association. A recent past president of that organization, Dr. Walter B. Martin, of Norfolk, Va., is also a director. Among the other directors is Dr. James J. Griffitts, of Miami, Associate Director of the John Elliott Blood Bank of Dade County and President of the American Association of Blood Banks.

The executive vice president and secretary of this new nonprofit organization is Dr. Frank E. Wilson, of Washington. For seven years Dr. Wilson has been with the American Medical Association's Washington office, the last three years as its director. Previously, he had had experience in developing blood bank programs and was the first secretary of the American Medical Association's Committee on Blood. He served five years on active duty with the Army during World War II and is a brigadier general in the medical reserves. Also, he is a diplomate of the American Board of Preventive Medicine. The Joint Blood Council headquarters office is at 1832 M Street, N.W., Washington, D. C.

Hawaii Medical Association Centennial Celebration April 22-29, 1956

Hawaii in the springtime is calling all physicians to help the Hawaii Medical Association celebrate its Hundredth Anniversary. April 22 to 29 are the dates, and the invitation, extended by Dr. Harry L. Arnold Jr., Editor of the Hawaii Medical Journal, promises that the occasion will be observed in proper "Hawaii" as well as medical fashion in famed Honolulu.

A short but worth while professional program is planned for Monday and Tuesday mornings, April 23 and 24. On Tuesday night there will be a spectacular Centennial Celebration Pageant, and on Thursday night, April 26, a traditional luau, or Hawaiian feast, with Polynesian entertainment will be featured.

This celebration is planned to follow the American College of Physicians' session in Los Angeles, April 16 to 20. It offers a unique opportunity to combine a professional meeting with a visit to America's island paradise in the spring when it is at its loveliest. The Hawaii Medical Association, 510 South Beretania St., Honolulu 13, Hawaii, will send reservations application forms on request.

Health Hazards of Chemicals

The public needs to become acquainted with the possible dangers of many chemical products being used today in the home, on farms, and in industry. There are about 25,000,000 chemical products now available for use in these three fields. It is estimated that there are a quarter of a million brand name chemical products on the market. They may all be useful, but if they are handled improperly, they may become killers, cripplers, and destroyers of property.

Understanding of the uses and the potential dangers of this wealth of available chemical products is needed to prevent some 3,300 deaths from accidental poisoning which occur annually as the result of misuse of chemicals. The array is so large and so many combinations of chemicals are possible that no complete catalogue of all available products has been made.

A campaign to spread information about these products and their hazards has been launched by the Committee on Toxicology of the American Medical Association. As a part of this effort, this committee, together with that organization's Committee on Pesticides, sponsored a symposium on health hazards of chemicals last December 29 before the Pharmacy Section at the annual meeting of the American Association for the Advancement of Science, in Atlanta, Ga. The purpose was to interpret new knowledge of chemical products to scientists in various fields, so that they in turn may use and spread the information.

(Additional editorials and commentaries may be found on page 662)



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Graduate Medical Education
Cardiology Course
Feb. 23-25, 1956

The Duval District Heart Association in cooperation with the Department of Medicine of the Graduate School of the University of Florida, the Florida Medical Association and the Florida State Board of Health will present a course in Cardiology on February 23, 24 and 25 at the Duval Medical Center auditorium in Jacksonville.

The lectures will be on cardiac diseases in childhood, congenital and acquired, adult cardiology and surgery of the heart. There will be panel discussions on both Thursday and Friday afternoons and a summary of these three phases on Saturday morning.

Dr. J. Francis Dammann Jr., Department of Surgery, University of Virginia School of Medicine, will give the lectures on pediatric cardiac diseases, and Dr. Robert P. Glover, Clinical Professor in Thoracic Surgery, Temple University School of Medicine, will discuss surgery of the heart. The adult phase of this subject will be presented by an internist not yet assigned.

The registration fee will be $10. Hospital interns and residents will be registered without charge. Advance registration is urged.

OTHERS ARE SAYING

Editorial

Dr. George Harrell, dean of the Medical School of the University of Florida, reminded us of some important statistics at the recent District Meetings of the Florida Medical Association. During the past five years the number of qualified applicants for admission to medical schools throughout the whole country has diminished alarmingly. The current official figure is something just under two for each available freshman vacancy. It is easy to remember when the number was closer to five. Wider acquaintance with these facts is clearly needed if we are to avoid the embarrassment of ignorance about the health of our own profession.

Why are so many of the better students passing up Medicine as a career? The high tide of applicants created by wartime and postwar government subsidies has receded as was expected, but the fall-off is much greater than that which could possibly be explained by immediate financial problems facing the would-be medical student. In many instances loan funds and even scholarships go begging. Apparently the old idea that an M.D. was worth much hard work and self sacrifice is being subjected to very realistic questioning.

To the scientific-minded, stimulus and challenge is certainly not lacking in today's Medicine, but Physics, Chemistry, Engineering, and related sciences offer greater freedom from sociologic and psychologic restrictions. In Medicine, technology must always defer to the social and psychological factors which control human behavior in sickness as well as in health. On the other hand, many a student is a "natural" humanist, possessed of a liking for people and a real desire to serve as physicians must, but so lacking in scientific aptitude that he cannot grasp elementary chemistry, much less the involved physics necessary to cope with the diagnostic and therapeutic apparatus required in current standard medical practice. To find the necessary blending of scientist and humanist is to discover a good medical student. The trouble is, he would also be a good student in almost any other field, and he knows it. So he would be foolish indeed to fail to look ahead to his possible rewards for effort and excellence.

If we wish to woo him, we cannot lie to him. We must tell him he could easily make twice as much money in almost any branch of commerce or industry after equivalent education and practical on the job training. We must tell him that he will enjoy much more prestige and good will by designing a gadget or improving a widget than he possibly could obtain by a lifetime of dedicated and able service in Medicine. We must admit that he will share in the apparently illimitable "guarantees" and "benefits" available and projected for "employed workers," but denied the so-called self-employed physicians. He may even aspire to that ultimate dizzy pinnacle of achievement, the miracle of being admired by his children as a "smart operator," if he chooses a career in industry. Our kids know we have rocks in our heads, so don't try to fool them.

Surprisingly, we do have something to offer the student. Possibly we haven't stressed it quite enough, assuming it speaks for itself. That thing is the challenge Medicine offers to the best of human brains and human effort. The appeal of the sick or the injured has a dramatic impact which far exceeds that of solar energy or even

space travel. Medicine and magic have been close companions since the very beginning. There's something very mysterious indeed when the bearing of a staggering burden of responsibility is a privilege rather than an imposition. This may be difficult to get across to young people nowadays, bemused as they often are by the cruel and utterly false illusion of "security above all else," but it is a job to be done by you and me.

DFM

—The Bulletin, Dade County Medical Association
November, 1955

Medical Officers Returned

Dr. Thomas M. Brill, who entered military service on September 15, 1952, was released from active duty on August 27, 1954, with the rank of lieutenant, U. S. Navy. His address is 907 S. W. 4th Avenue, Gainesville.

Dr. Russell L. Counts, who entered military service on February 21, 1953, was released from active duty on February 21, 1955, with the rank of captain, U. S. Air Force. His address is 1223 Delaware Ave., Fort Pierce, Fla.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Anderson, George A., Jacksonville
Browning, Malissa D., Miami
Cunningham, Gene C., Tampa
Fergeson, James O., St. Petersburg
Foraker, Alvan G., Jacksonville
Furr, Walter E. Jr., Coral Gables
Gleaton, Carroll W., Tampa
Halperin, Bernard, Miami Springs
Kaupe, Arthur P., Riviera Beach
Klenk, Leo F., Jacksonville
Liebler, John B., Coral Gables
Miller, Richard J. Jr., Tampa
Pace, Sherman H., Clearwater
Padgett, Glenn E., Marianna
Reinstine, Harry W. Jr., Jacksonville
Simpson, Dazelle D. (Col.), Miami
Steele, Hugh G., Tampa
Tierney, Kaden, Riviera Beach
Von Storch, Theodore, J., Miami
Young, Ulysses A., Tampa

BIRTHS AND DEATHS

Births

Dr. and Mrs. Thomas G. Ritch of Starke announce the birth of a son, Richard Clifton, on December 17, 1955.

Dr. and Mrs. Thomas W. Meldrum of Jacksonville announce the birth of a son, Donald Leslie, on November 22, 1955.

Deaths — Members

Hall, Frank M., Gainesville	Dec. 23, 1955

Deaths — Other Doctors

Baerecke, Vida Z., Orange City	Jan. 30, 1952
Butler, F. Eugene (Col.), Chicago, Ill.	Sept. 2, 1943
Drew, Clarence L., Monticello	Oct. 8, 1950
Morrison, Harry K., Leesburg	Dec. 9, 1955
Sommerfield, William A., Sarasota	Nov. 26, 1955

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STATE NEWS ITEMS

The regular fall business and scientific meeting of the Florida Society of Anesthesiologists was held late in November at Miami. Appearing on the program were Drs. William H. Derry; Earl S. Huntley Jr. and William H. Forthman of Miami, and Dr. John T. Stage of Jacksonville.

Dr. Derry discussed the "Clinical Impressions of Dolitrone," and Dr. Huntley "Some Aspects of Bellafoline." The title of Dr. Forthman's address was "Pharmacology of Succinylcholine," and that of Dr. Stage "Electrolyte and Fluid Balance in Anesthesia."

Physicians from Florida who attended the 1955 Clinical Session of the American Medical Association in Boston, November 29-December 2 were Drs. Bruce Cominole and Herbert A. King, Daytona Beach; Dr. Rothwell C. Polk, Jacksonville; Drs. Reuben B. Chrisman Jr., Homer L. Pearson Jr. and Herbert W. Virgin Jr., Miami; Dr. Carl S. Lytle, Ocala; Drs. Russell L. Counts and Louis M. Orr, Orlando; Drs. Walter H. Bailey and Harry W. Brown, St. Petersburg, and Dr. Francis T. Holland, Tallahassee.

Dr. Mason Trupp of Tampa was guest speaker at a late November meeting of the Tarpon Springs Rotary Club. The title of his address was "The Most Important Part of Us."

Dr. Hawley H. Seiler of Tampa was reelected secretary-treasurer of the Southern Thoracic Surgical Association at its recent meeting at the Greenbrier, White Sulphur Springs, W. Va.

Dr. Robert J. Boucek of Miami has been appointed associate professor of medicine in cardiology at the University of Miami School of Medicine. Dr. Boucek will also serve as director of the Department of Cardiology.

Dr. Anthony C. Galluccio of Hollywood was the principal speaker at a recent meeting of the Rotary Club there. He is an official of the Broward County Chapter of the Tuberculosis and Health Association.

Dr. Carl H. Wells of Jacksonville has been appointed medical examiner for Duval county to succeed Dr. Robert Y. H. Thomas whose resignation became effective December 31.

Dr. Louis M. Orr of Orlando was one of the speakers on the program of the Los Angeles Midwinter Medical Convention held January 3-5 in Los Angeles. The title of his address was "Aspects of Surgery in the Geriatric Patient."

Dr. Elwyn Evans of Orlando has been selected chairman in Florida of the T. Duckett Jones Memorial Fund, and Dr. Jean J. Perdue of Miami Beach has been named to the Fund's national committee. The memorial honors the late Dr. Jones, a famed authority on rheumatic fever and rheumatic heart disease.

Donations to the Fund are to be used primarily to establish research fellowships for promising young scientists interested in rheumatic fever. However these fellowships may not be given exclusive claim. Depending on the amount collected, there are a number of awards which might be made to represent the philosophy and professional interests of Dr. Jones.

Several of these have been suggested, such as fellowships for young investigators until they become eligible for permanent appointments; short-term support for investigators holding permanent positions to permit temporary leave in order to complete a study or a project, and establishment in a university of a T. Duckett Jones Professorship in an appropriate field.

Florida physicians who would like to have a part in the undertaking may send their donations to the T. Duckett Jones Memorial Fund, 525 East 68 Street, New York 21, N. Y.

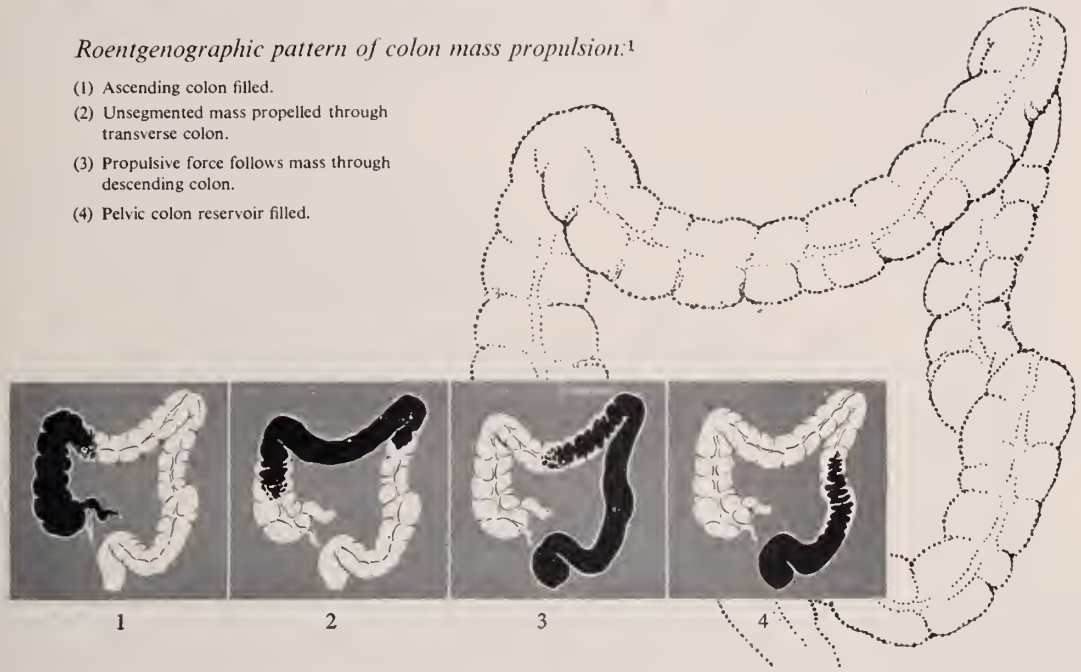
Dr. John M. Schultz of Miami was inducted into Fellowship in The American Academy of Obstetrics and Gynecology during the Fourth Annual Clinical Meeting of the Academy held the middle of December in Chicago.

The V Congress of Pan American Medical Women's Alliance will be held in Santiago and Vina del Mar, Chile, March 6-14, 1956. Opportunities for sight seeing and visits to medical programs in Mexico, Salvador, Panama, Chile, Bolivia and Peru have been arranged. Information may be obtained from the Secretary, Dr. Eva F. Dodge, 2124 West 11th St., Little Rock, Ark.

SMOOTHAGE ACTION IN CONSTIPATION

Roentgenographic pattern of colon mass propulsion:[1]

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(2) Unsegmented mass propelled through transverse colon.
(3) Propulsive force follows mass through descending colon.
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Correction of constipation logically, therefore, lies in the suitable adjustment of these factors. The characteristics of Metamucil permit the correction of most of these factors: it provides bulk; it demands adequate intake of fluids (one glass with Metamucil powder, one glass after each dose); it increases the physiologic demand to evacuate; and it does not establish a laxative "habit." Metamucil, in addition, is inert, and also nonirritating and nonallergenic.

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1. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice: A Text in Applied Physiology, ed. 5, Baltimore, The Williams & Wilkins Company, 1950, pp. 579-583.
2. Bargen, J. A.: A Method of Improving Function of the Bowel, Gastroenterology *13*:275 (Oct.) 1949.

SEARLE

Dr. Frank A. Massari of Tampa has been elected an Associate in the American College of Physicians. The action took place at the November meeting of the Board of Regents of the College held at Philadelphia.

Dr. Redden L. Miller of Graceville has been named "Man of the Year" by the Lions Club there. He is a native of the Miller's Cross Roads area of Holmes county and has served as physician for hundreds of families within a 60 mile radius of Graceville for 54 years.

Drs. Samuel M. Day, Joseph A. J. Farrington, Melvin Newman, William A. Van Nortwick, Edward C. Watt and Donald P. White Jr. were among the group of Jacksonville physicians who attended the 49th annual meeting of the Southern Medical Association held in Houston.

Dr. J. Sudler Hood of Clearwater was principal speaker at an early December meeting of the Rotary Club of that city.

Drs. Grover W. Austin, Irvin S. Leinbach, Chas. B. Cunningham and Rodes C. Garby of St. Petersburg, and Dr. Edward I. Melich of Bay Pines appeared on the program of the annual meeting of the Florida Association of Nurse Anesthetists held early in December at St. Petersburg.

Dr. Frederick H. Bowen of Jacksonville presented a paper on "Choledochal Cysts" at the meeting of the Southern Surgical Association held recently at Hot Springs, Va. Other Jacksonville physicians who attended the meeting were Drs. Kenneth A. Morris and Wilbur C. Sumner.

Dr. James C. Rinaman of St. Cloud conducted a first aid course for the health and safety departments of local clubs there the first of January.

Dr. Willard F. Ande of West Palm Beach presented a program on cancer research at a meeting of the Lions Club there early in December.

Drs. Jack H. Bowen, William C. Croom Jr. and Lauren M. Sompayrac of Jacksonville attended the annual meeting of the American Academy of Dermatology and Syphilology held recently in Chicago.

Drs. Archibald F. Caraway Jr. and E. Frank McCall of Jacksonville have returned from Chicago where they attended the annual meeting of the American Academy of Obstetrics and Gynecology.

Dr. Alvan G. Foraker of Jacksonville has been awarded a three year grant by the National Cancer Institute for the support of a research project entitled "Cytochemical Orientation of Intraepithelial Carcinoma of the Cervix." Dr. Foraker has also been notified by the Damon Runyon Memorial Fund of a supplement to a previous award which is to be used primarily for the purchase of an interference contrast microscope with photomicrographic accessories. The instrument will be employed in the project supported by Institute funds.

Dr. Ralph W. Jack of Miami; Dr. H. Quillian Jones of Fort Myers, and Dr. George W. Morse of Pensacola have been appointed to the Medical Advisory Board of the State Welfare Department.

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A regional meeting of the Mid-Atlantic Section of the International College of Surgeons is being held at the Greenbrier Hotel, White Sulphur Springs, W. Va., February 13-15. Scientific papers are to be presented on the morning of each day leaving the afternoons free for entertainment purposes. There will also be one evening session. Reservations may be obtained from the Greenbrier Hotel.

Dr. Meredith F. Campbell of Miami was one of the principal speakers for the postgraduate seminar in urology sponsored by the North Central Section of the American Urological Association at the Mayo Clinic, Rochester, Minn., early in December. Dr. Campbell presented three lectures at the seminar: "Anonmalies of the Lower Urinary Tract," "Anorectal Anomalies," and "Hermaphrodism and Other Problems in Intersex."

Drs. C. Frank Chunn and David R. Murphey Jr. of Tampa attended the meeting of the Southern Surgical Association held recently at Hot Springs, Va.

Dr. Joseph W. Scott of Miami addressed a recent meeting of the British West Indies Medical Association at Kingston, Jamaica. The subject chosen by Dr. Scott was "Early Carcinoma of the Cervix."

Dr. Samuel M. Day of Jacksonville discussed "Quacks in Medicine" January 5 at two meetings of supervisory personnel and bus drivers of the Jacksonville Coach Company. Dr. Day, who is secretary-treasurer of the Florida Medical Association, addressed the groups at 10 a.m. and again at 2 p.m.

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COMPONENT SOCIETY NOTES

Bay

Dr. Joseph H. Morris has been elected president of the Bay County Medical Society. Chosen to serve with him are Dr. Sidney E. Daffin, as vice president; Dr. John J. Hollomon Jr., as secretary, and Dr. James A. Poyner, as treasurer. All are from Panama City.

Approximately 75 physicians from northwest Florida and southern Alabama attended the Society's first annual scientific dinner meeting held the first of December. Principal speakers were Dr. J. Ernest Ayre, of Miami, and Dr. Wallace Clarke, of New Orleans.

Broward

Dr. Thomas F. Huey Jr., of Fort Lauderdale, will serve as president of the Broward County Medical Association for 1956. He was chosen president-elect at the annual meeting last year. Dr. Walter J. Glenn Jr., of Fort Lauderdale, has been elected president-elect. Other newly elected officers include Dr. Russell R. Hippensteel, of Hollywood, vice president; Dr. Anthony C. Galluccio, of Hollywood, secretary, and Dr. Richard L. Foster, of Fort Lauderdale, treasurer.

Columbia

Dr. Thomas H. Bates, of Lake City, was chosen president of the Columbia County Medical Society at the annual business meeting held early in December. Elected vice president was Dr. Robert M. Sasso, Lake City. Serving with Drs. Bates and Sasso will be Dr. Clifton G. York as secretary-treasurer. Dr. York is also from Lake City.

Dade

Dr. Hunter B. Rogers, of Miami, will serve as president of the Dade County Medical Association for 1956. He was chosen president-elect at the 1955 annual meeting. Dr. Walter W. Sackett Jr., of Miami, has been chosen to serve as president-elect for the current year. Vice president will be Dr. Nelson Zivitz, of Miami Beach. Dr. Vincent P. Corso, of Miami, was elected secretary, and Dr. Franklin J. Evans, of Coral Gables, treasurer.

DeSoto-Hardee-Highlands-Glades

Newly elected officers of the DeSoto-Hardee-Highlands-Glades County Medical Society are Dr. Merle C. Kayton, president; Dr. Miles A. Collier, vice president, and Dr. Roland W. Banks, secretary-treasurer. All are from Wauchula and were elected during the Society's annual meeting held the first of December at Wauchula.

Duval

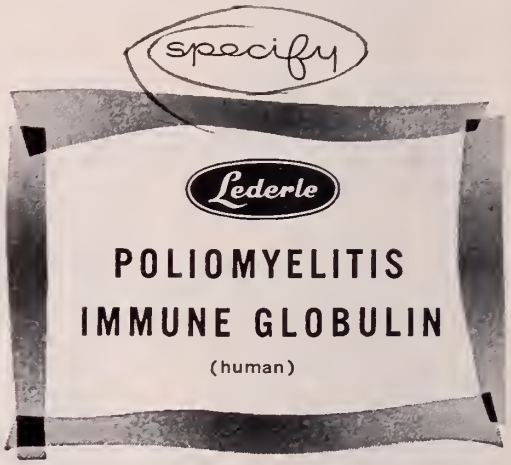
Dr. Joseph J. Lowenthal, elected president-elect of the Duval County Medical Society at the annual meeting last year, was installed as president at the 1956 annual meeting held the first of December. Elected at this time to serve with Dr. Lowenthal were Dr. Leo M. Wachtel Jr., president-elect; Dr. James C. Lanier, vice president; Dr. Charles F. McCrory, secretary, and Dr. Sidney Stillman, treasurer. Dr. G. Dekle Taylor succeeded Dr. Lanier as chaplain.

Dr. Louis C. Clerf, professor emeritus of laryngology and bronchoesophagology at the Jefferson Medical College of Philadelphia, was principal speaker at the Society's January meeting held in Sellers Auditorium.

Escambia

Dr. Gretchen V. Squires, of Pensacola, was installed as president of the Escambia County Medical Society during the regular monthly meeting held the first of January. Dr. Squires served as president-elect last year.

(Continued on page 674)



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1. Moyer, J.H., in discussion of Galen, W.P., and Duke, J.E.: Outpatient Treatment of Hypertension with Hexamethonium and Hydralazine, South. M J. *47*:858 (Sept.) 1954.

2. Moyer, J.H.; Dennis, E., and Ford, R.: Drug Therapy (Rauwolfia) of Hypertension. II. A Comparative Study of Different Extracts of Rauwolfia When Each Is Used Alone (Orally) for Therapy of Ambulatory Patients with Hypertension, A.M.A. Arch. Int. Med. *96*:530 (Oct.) 1955.

3. Wilkins, R.W.; Stanton, J.R., and Freis, E.D.: Essential Hypertension. Therapeutic Trial of Veriloid, a New Extract of Veratrum viride, Proc. Soc. Exper. Biol. & Med. *72*:302 (Nov.) 1949.

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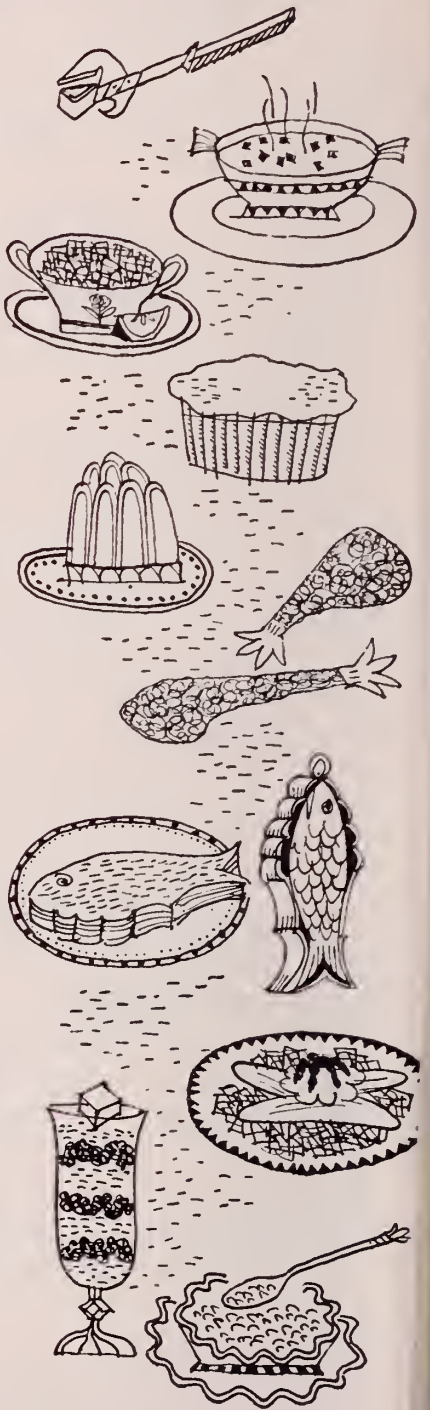
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Rice cooked in pineapple juice, water, and sugar makes a golden dessert. And for a gay parfait—alternate layers of farina pudding with puréed plums. Then put a sparkling cube of clear jelly on top.

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Dr. Paul F. Baranco, also of Pensacola, has been chosen president-elect. He was formerly secretary-treasurer of the Society. Dr. J. Melvin Young has been elected vice president, and Dr. Pascal G. Batson Jr., secretary-treasurer. Drs. Young and Batson are from Pensacola.

Franklin-Gulf

Dr. Harold B. Canning, of Wewahitchka, began serving as president of the Franklin-Gulf County Medical Society the first of 1956 following his election at the Society's annual meeting the last of November. Dr. John W. Hendrix, of Port St. Joe, became vice president, and Dr. Photis J. Nichols, of Apalachicola, secretary-treasurer.

Hillsborough

Dr. James N. Patterson, of Tampa, has been installed as president of the Hillsborough County Medical Association. He was chosen president-elect at the annual meeting last year.

Elected at the 1956 annual meeting early in December to succeed Dr. Patterson as president-elect was Dr. Frank C. Metzger, also of Tampa. Other new officers for the year include Dr. Madison R. Pope, of Plant City, vice president, and Dr. James A. Winslow Jr., Tampa, secretary. Dr. Curtis G. Rorebeck, of Tampa, was reelected treasurer.

The Association's January meeting was held at Anclote Manor in Tarpon Springs. Principal speaker was Dr. Zack Russ Jr. whose subject was "Psychiatry in a General Hospital."

Jackson-Calhoun

Dr. Richard H. Schulz, of Marianna, has been elected president of the Jackson-Calhoun County Medical Society. Dr. William W. Richardson, of Graceville, will serve with Dr. Schulz as vice president, and Dr. Francis M. Watson, of Marianna, as secretary-treasurer. Dr. Watson was reelected. Selection of officers for the new year took place during the Society's annual meeting early in December.

Lake

New officers of the Lake County Medical Society are Dr. Geoffrey H. Binneveld, of Leesburg, president, and Dr. Rabun H. Williams, of Eustis, vice president. Dr. J. Basil Hall, of Tavares, was reelected secretary-treasurer.



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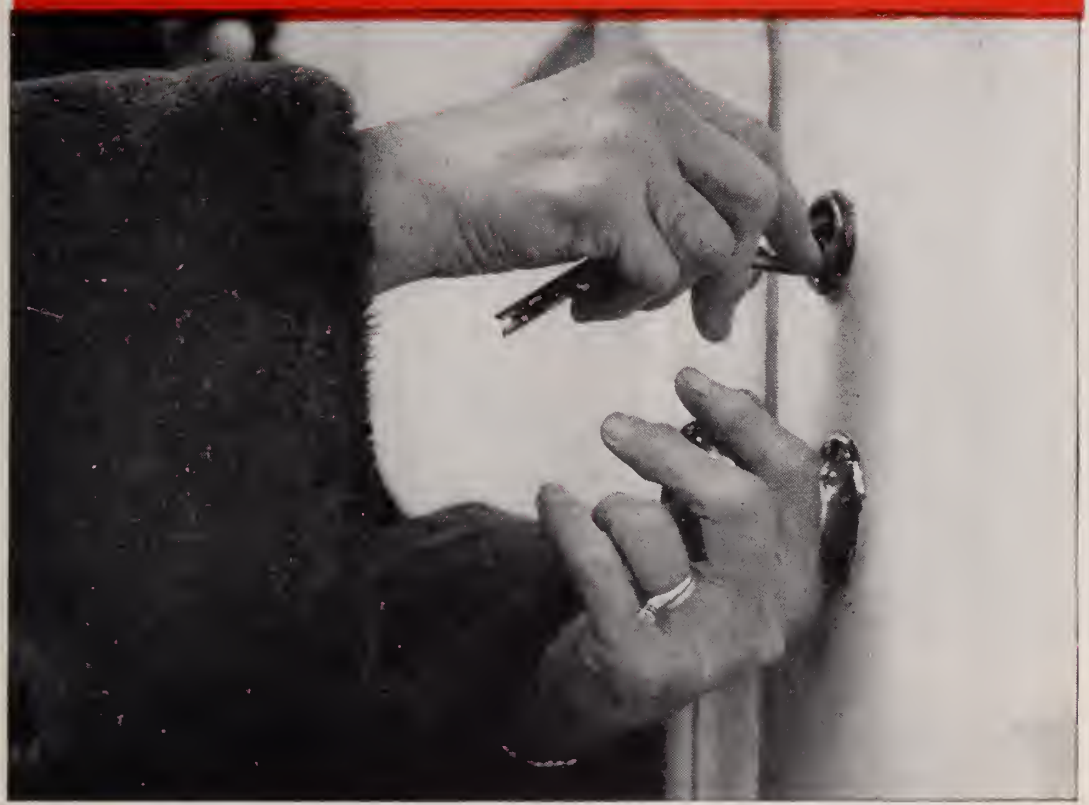
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REFERENCES: 1. Boland, E. W. and Headley, N. E., *J.A.M.A.* **148**:981, March 22, 1952. 2. Ward, L. E., Polley, H. F., Slocumb, C. H. and Hench, P. S., *J.A.M.A.* **152**:119, May 9, 1953. 3. Snow, W. B. and Coss, J. A., *N.Y. State J. Med.* **52**:319, Feb. 1, 1952.

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(Continued from page 676)

Palm Beach

Dr. Walter R. Newbern, of West Palm Beach, has been installed as president of the Palm Beach County Medical Society. Dr. Newbern was selected president-elect at the Society's annual meeting last year. Dr. Edward W. Wood, of Lake Worth, has been chosen to succeed Dr. Newbern as president-elect.

Dr. James R. Anderson, of West Palm Beach, formerly secretary of the Society, has been elected vice president, and Dr. Horace D. Atkinson, of West Palm Beach, has become secretary. Dr. Russell D. D. Hoover, also of West Palm Beach, has been chosen as treasurer.

Pasco-Hernando-Citrus

Dr. Gail M. Osterhout, of Inverness, was elected president of the Pasco-Hernando-Citrus County Medical Society during the regular monthly meeting held the first of December. Vice presidents elected to serve with Dr. Osterhout were Dr. S. Carnes Harvard, of Brooksville, and Dr. John S. Williams, of Dade City. Dr. W. Wardlaw Jones, of Dade City, was reelected secretary-treasurer.

Pinellas

Dr. Percy H. Guinand, of Clearwater, has been installed as president of the Pinellas County Medical Society. Dr. Guinand was chosen president-elect at the annual meeting last year.

Vice presidents elected to serve with Dr. Guinand are Dr. Harry R. Cushman, of St. Petersburg, first, and Dr. Edward L. Cole Jr., of St. Petersburg, second. Dr. Whitman C. McConnell, of St. Petersburg, was reelected secretary-treasurer.

Polk

Dr. James T. Shelden, of Lakeland, has been installed as president of the Polk County Medical Association for the year 1956. He succeeds Dr. Samuel J. Clark, also of Lakeland. Dr. Marion W. Hester, of Lakeland, has been reelected secretary-treasurer.

St. Lucie-Okeechobee-Martin

Dr. Alfred J. Cornille, of Fort Pierce, has been elected president of the St. Lucie-Okeechobee-Martin County Medical Society. Dr. John M. Gunsolus, of Stuart, has been chosen vice president, and Dr. Adrian M. Sample, of Fort Pierce, has been reelected secretary.

KNOX Protein Previews





New Study Shows Gelatine
Restores Brittle Fingernails to Normal

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Brittle, fragile or laminating fingernails are the bane of many a woman's existence. Yet this highly prevalent and distressing condition often has gone uncontrolled for lack of effective therapy. Now, you can promise these patients substantial relief in a large percentage of cases.

In a recent study[1] that confirmed previous work[2] Knox Gelatine was used to treat 36 women with fragile, brittle, laminating fingernails. The response was most gratifying. Except for three patients who discontinued the therapy, three diabetics, and two women who had congenital deformities, the splitting ceased and all other patients were able to manicure their nails to a full point by the time the study ended.

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1. Rosenberg, S. and Oster, K. A., "Gelatine in the Treatment of Brittle Nails," *Conn. State Med. J.* 19:171-179, March 1955.
2. Tyson, T. L., *J. Invest. Dermat.* 14:323, May 1950.

Chas. B. Knox Gelatine Company, Inc.
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Please send me a reprint of the article by Rosenberg and Oster with illustrated color brochure.

YOUR NAME AND ADDRESS

St. Johns

Dr. Reuben J. Plant Jr., of St. Augustine, has been elected president of the St. Johns County Medical Society. Dr. Plant served last year as secretary of the Society. Dr. Milton Segal, of St. Augustine, has been chosen vice president; Dr. Roy E. Campbell, secretary, and Dr. Richard J. Langston, treasurer. Drs. Campbell and Langston are also from St. Augustine.

Sarasota

New officers of the Sarasota County Medical Society are Dr. Eugene D. Liddy Jr., president; Dr. Karl R. Rolls, secretary, and Dr. Millard B. White, treasurer. All are from Sarasota.

Seminole

Dr. William V. Roberts will serve the Seminole County Medical Society as president during the year 1956. Serving with him will be Dr. Gordon D. Stanley, as vice president, and Dr. Terry Bird, as secretary. Dr. Bird was reelected. All the officers are from Sanford.

Volusia

Dr. Theodore F. Hahn Jr., of DeLand, has been elected president of the Volusia County Medical Society. Dr. Lawrence M. Hughes, of New Smyrna Beach, will serve with him as vice president.

Dr. Achille A. Monaco, of Daytona Beach, has been reelected secretary-treasurer. Selection of officers came during the regular monthly meeting of the Society held the middle of December at Daytona Beach.

Dr. Peter B. Wright, of Orlando, was principal scientific speaker at the meeting. He presented the program of the Trauma Committee for the American College of Surgeons. Following Dr. Wright's address, Dr. Eugene L. Jewett, of Orlando, presented the film of the Safety Research Program at the Cornell University Medical School.

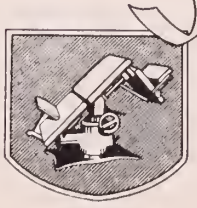
The names of the officers of the county medical societies not included in this section of The Journal will be published as they are received in the offices of the Florida Medical Association. Societies are requested to forward the names promptly in order that Association records may be completed.

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—Bullein, W.: Government of Health, 1595.

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1. McLester and Darby: "Nutrition and Diet in Health and Disease," ed. 6, Saunders, p. 195. 2. McCay, C. M., in Lansing: "Problems of Aging," ed. 3, Williams and Wilkins, 1952, p. 193. 3. Sebrell and Hundley, in Stieglitz: "Geriatric Medicine," ed 3, Lippincott, 1954, p. 189.

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Here Is the Factual Story

The Ford Foundation grant of $90,000,000 for 42 privately endowed medical schools has been hailed by all who are interested in seeing the standards of medicine at the highest level as a great aid and help in distress for those schools. However, there seems to be some confusion about this grant and what it means so let's get the factual story on it.

The Ford Foundation has given $90,000,000 to be used "to help strengthen instruction," however it is *only the interest from this amount that is to be used each year.* Thus instead of an outright grant amounting to more than $2,000,000 per medical school, there will be a *yearly yield in interest* of about $3,500,000 to $4,000,000, this amount to be divided among the medical schools each year.

If the Ford Foundation, which has not yet allocated this amount school by school, should give an equal amount to each school of medicine, each would receive yearly about $85,000. This is a wonderful gift and surely the Ford Foundation has pointed the path to the necessity of our keeping the medical schools untrammeled

(Continued on page 690)

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Erythromycin in treatment of abscess

6/21/55

DISCHARGE SUMMARY

On 5/23/55 this patient (colored female, age 24) underwent an excisional biopsy of a breast tumor. On 5/24 tumor was removed and patient discharged from hospital on following day.

On 6/3/55 patient was readmitted because of purulent discharge from wound. On 6/3 a hemolytic Staph. aureus (coag. +) was isolated from abscess with the following disk sensitivities: penicillin, 1.5 units; erythromycin, 10 mcg; tetracycline, 10 mcg. Patient was placed on penicillin, 600,000 units b.i.d. for 10 days. On this schedule patient improved but progress was unsatisfactory and wound continued to discharge small amount of purulent material.

On 6/13 penicillin was discontinued and erythromycin started in dosage of 200 mgm. q.i.d. By 6/17 the discharge had stopped and wound was completely healed by 6/19. Erythromycin was continued until the patient was discharged from hospital on 6/21. Temp. was normal throughout hospital stay.

Final diagnosis: breast abscess due to Staph. aureus.

Result: rapid and complete recovery on erythromycin following failure of penicillin.

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(Continued from page 686)

and without control or interference from the federal government.

Let us now compare this gift with the needs of the schools each year, which is $10,000,000 more than they have at present. With the aggregate funds received from the Ford Foundation endowment, some $3,500,000 to $4,000,000, we will still be short about $6,000,000 needed for medical schools to increase their student bodies and to maintain sufficient teaching staff to keep the high standard of medical education they now enjoy.

During the period the National Fund for Medical Education has been in existence, a little more than four years, its funds have been responsible for some $9,000,000 for medical education but as anyone can see from the above figures, this $9,000,000 spread over a period of more than four years, falls far short of the $10,000,000 per year needed.

Last year, the National Fund for Medical Education raised $2,500,000 which would be the equivalent of four per cent interest on $62,500,000, but this amount was actually contributions from business, industry, the public and the doctors and not interest from $62,500,000.

The National Fund for Medical Education is composed of outstanding men who have recognized that our medical schools are one of the major resources of our country. They, believing as we do, that federal interference and control of eduaction could lead to the socialization of medicine throughout our country, have contributed their time and money, and dedicated their interests to keeping our medical schools safe through voluntary contributions.

The American Medical Education Foundation, which is the branch of this national fund for contributions from doctors, has its offices in the A.M.A. building in Chicago. The A.M.A., with a part of each doctor's dues, pays the expenses of running this office so that every cent of every contribution can be sent to the medical schools, either on a basis of allocation by need, if funds are not earmarked for a certain school, or if the doctor earmarks his contribution, the money goes right to that medical school.

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Through the American Medical Education Foundation, the A.M.A. Auxiliary, together with the state and local auxiliaries make a contribution every year. Last year our contribution in aggregate was over $80.000. In many states, the contributions of the women in the auxiliary were in excess of the money given by the doctors.

I have listened to medical people talk, or perhaps prate would be a better word, about their belief in the free enterprise system, their belief in less governmental interference and more dependence of people upon themselves to care for the welfare and health needs of our nation. The "talk" on these subjects is justified only if those who talk contribute in a tangible manner to aid in keeping our free enterprise system. The talk becomes "prating" when those who speak do not contribute.

The impressive Ford Foundation grants have focused national attention on the plight of our medical schools. This allocation amounts to a truly blue-chip recognition of the need. It challenges American business, the American public, but most surely the American medical profession to bring adequate, effective financial support to medical education so that all the schools may be upon a firm and solvent footing for maintaining our high quality of doctor training, research and the schools many contributions to health services.

We have a job to do. Yes, both the medical profession and those of us married into it have a job to do — a job which will provide our medical schools the funds they need to expand in a sound and positive manner and which will keep our standards of medical education the highest in the world. Let us, in Florida, come to the aid of the medical schools and know that we have done our share in maintaining their high standards without sacrificing the freedom of education they now enjoy.

Mrs. Richard F. Stover

The annual meeting of the Woman's Auxiliary to the Florida Medical Association is being held at Miami Beach, May 13-16, 1956, in the Hotel Fontainebleau. The meeting takes place concurrently with the Eighty-Second Annual Meeting of the Association.



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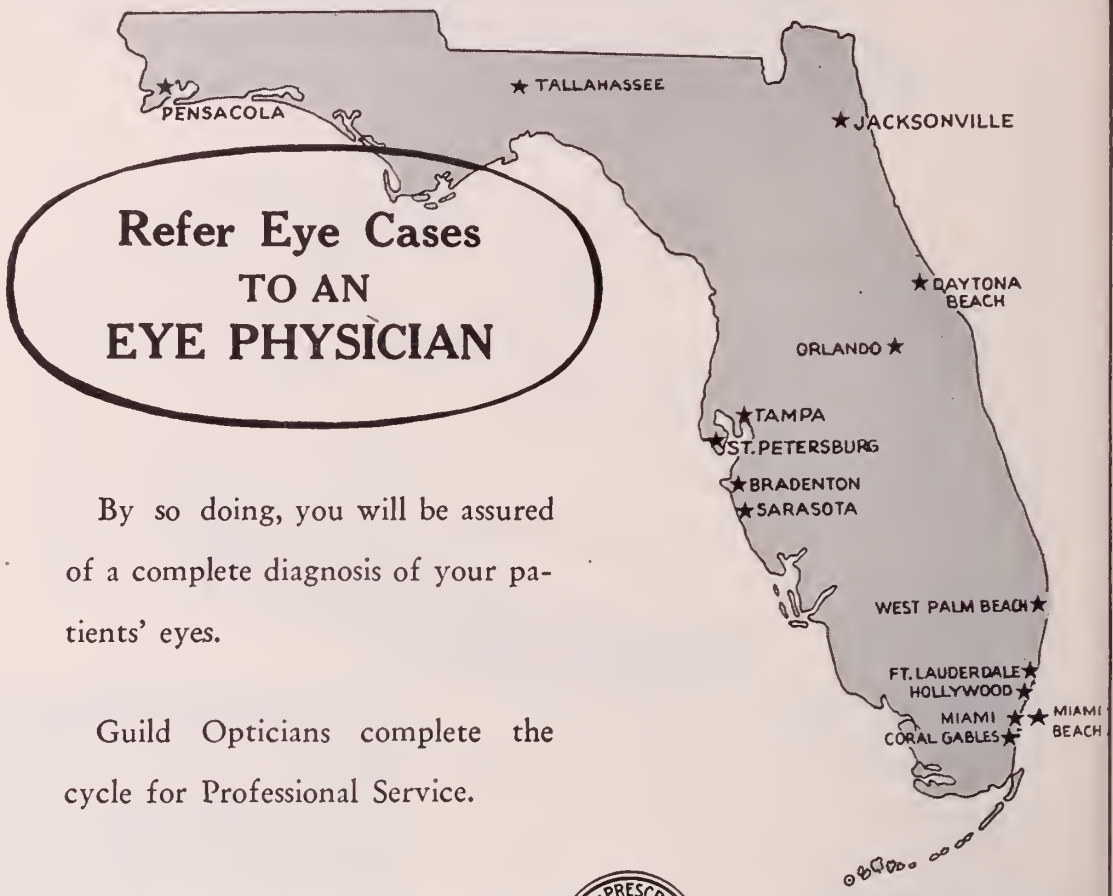
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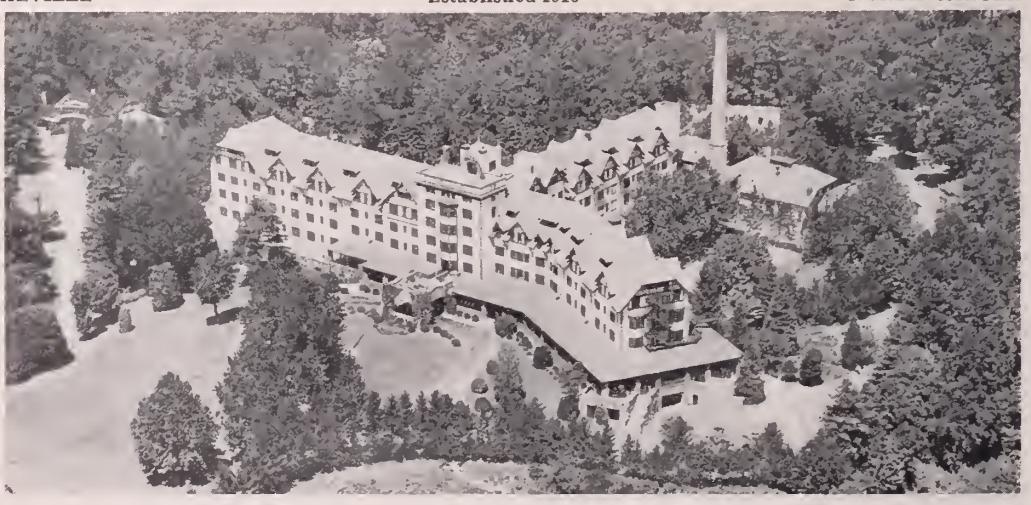
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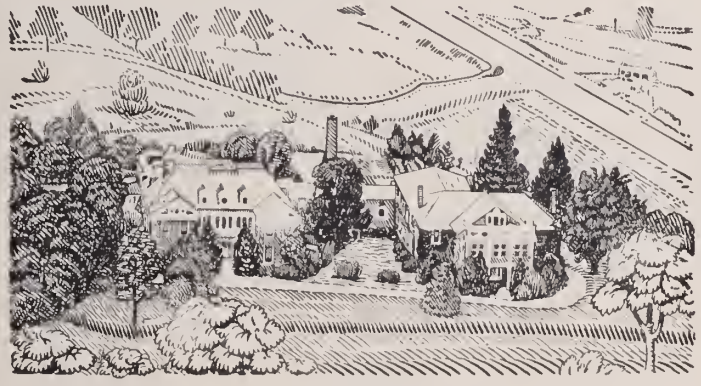
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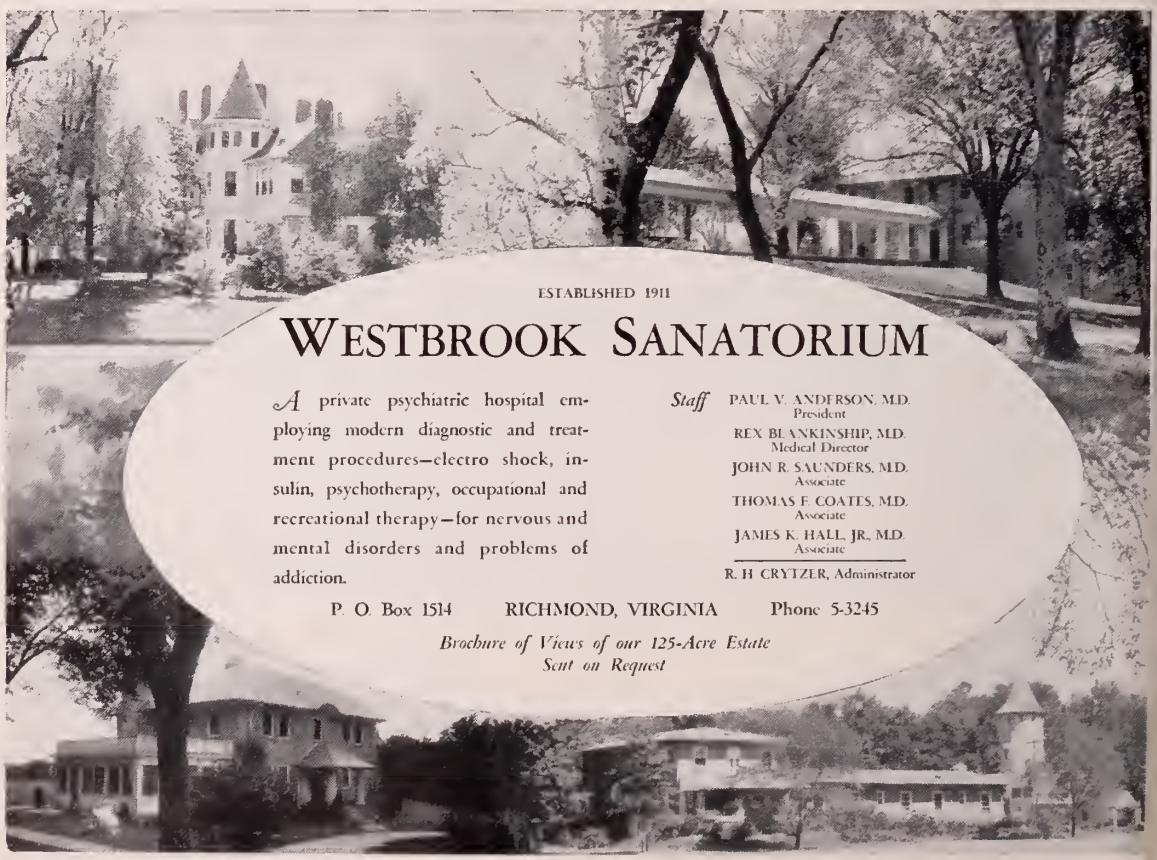
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-Northeast	Henry J. Babers Jr., Gainesville	Charles L. Park Sr., Sanford	Ocala
-Southwest	C. Frank Chunn, Tampa	James R. Boulware Jr., Lakeland	Tampa
-Southeast	James R. Sory, West Palm Beach	Ralph S. Sappenfield, Miami	West Palm Beach
rida Specialty Societies			
demy of General Practice	Frank T. Linz, Tampa	James B. Hodge Jr., Tampa	Miami Beach, May 13, '56
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opedic Society	Edward W. Cullipher, Miami	Robert P. Keiser, Coral Gables	" " " "
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tologic Society	Thomas F. Nelson, Tampa	George Williams Jr., Miami	" " " "
iological Society	Hugh G. Reaves, Sarasota	Donald H. Gahagen, Ft. Laud'dale	
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logical Society	David W. Goddard, Daytona Bch.	W. Dotson Wells, Fort Lauderdale	" " " "
rida—			
asic Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Miami, June 9, '56
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lue Cross of Florida, Inc.	Mr. C. DeWitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	
lue Shield of Florida, Inc.	Wayland T. Coppedge Jr., Jax.	John T. Stage, Jacksonville	Miami Beach, May '56
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ental Society, State	T. A. Price, D.D.S., Miami	W. A. Buhner, D.D.S., Daytona B.	Miami Beach, May 28-30 '56
eart Association	Victor H. Kugel, Miami Beach	Edwin P. Preston, Miami	Miami Beach, May 9-12, '56
ospital Association	Mr. Pat N. Groner, Pensacola	Mr. Steve F. McCrimmon, C. Gbls.	
edical Examining Board	Morris B. Seltzer, Daytona Bch.	Homer L. Pearson Jr., Miami	Miami Beach, June 24-26, '56
edical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 25-29, '56
urse Anesthetists, Fla. Assn.	Miss Dorothy Jackson, C. Gables	Mrs. Lulla F. Bryan, Miami	June 24-26, '56
urses Association, State	Martha Wolfe R.N., Coral Gables	Agnes Anderson, R.N., Orlando	
armaceutical Assoc., State	Miss Frances Walpole, Sarasota	Mr. R. Q. Richards, Ft. Myers	Clearwater, May 20-23, '56
iblic Health Association	L. L. Parks, Jacksonville	N. J. Schneider, Ph.D., Jax	Jacksonville, Apr. 12-14, '56
rudeau Society	Harold W. Johnston, Orlando	Howard M. DuBose, Lakeland	Jacksonville, Apr. 12-14, '56
berculosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mr. Ernest L. Abel, W. Palm Bch.	Jacksonville, Apr. 12-14, '56
oman's Auxiliary	Mrs. Samuel Lombardo, J'sonville	Mrs. Leffie M. Carlton Jr., Tampa	Miami Beach, May 13-16, '56
rican Medical Association	Elmer Hess, Erie, Pa.	Geo. F. Lull, Chicago	Chicago, June 11-15, '56
M.A. Clinical Session	Elmer Hess, Erie, Pa.	Geo. F. Lull, Chicago	Seattle, Nov. 27-30, '56
hern Medical Association	W. Ray McKenzie, Balti., Md.	Mr. V. O. Foster, Birmingham	Washington, Nov. 12-15, '56
ama Medical Association	F. L. Chenault, Decatur	Douglas L. Cannon, Montgomery	Birmingham, Apr. 19-21, '56
gia, Medical Assn. of	H. Dawson Allen Jr., Milledgeville	David Henry Poer, Atlanta	Atlanta, May 13-16, '56
Hospital Conference	Mr. D. O. McClusky Jr. Tuscaloosa, Ala.	Mr. Pat Groner, Pensacola	Miami Beach, Apr. 18-20, '56
heastern Allergy Assn.	Ben Miller, Columbia, S. C.	Kath. B. MacInnis, Columbia, S.C.	Charlotte, N. C., Oct. 5-6, '56
heastern, Am. Urological Assn.	Sidney Smith, Raleigh, N. C.	Robert F. Sharp, New Orleans	Hollywood, Mar. 25-29, '56
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SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Active Members
Alachua			2nd Tues.	
**Bradford, Gilchrist, Union*				
Bay	Joseph H. Morris, Panama City	John J. Hollomon Jr., Panama City	1st Tues.	
Brevard			2nd Tues.	
Broward	Thomas F. Huey Jr., Fort Lauderdale	Anthony C. Galluccio, Hollywood	4th Tues.	
Columbia	Thomas H. Bates, Lake City	Clifton G. York, Lake City	1st Mon.	
**Baker*				
Dade	Hunter B. Rogers, Miami	Vincent P. Corso, Miami	1st Tues.	
DeSoto-Hardee-Highlands-Glades	Merle C. Kayton, Wauchula	Roland W. Banks, Wauchula	1st Tues.	
Duval	Joseph J. Lowenthal, Jacksonville	Charles F. McCrory, Jacksonville	1st Tues.	
**Clay*				
Escambia	Gretchen V. Squires, Pensacola	Pascal G. Batson Jr., Pensacola	2nd Tues.	
**Santa Rosa*				
Franklin-Gulf	Harold B. Canning, Wewahitchka	Photis J. Nichols, Apalachicola	Last Wed.	
Hillsborough	James N. Patterson, Tampa	James A. Winslow Jr., Tampa	1st Tues.	
Indian River	Vernon L. Fromang, Vero Beach		2nd Tues.	
Jackson-Calhoun	Richard H. Schulz, Marianna	Francis M. Watson, Marianna	Quarterly	
Lake	Geoffrey H. Binneveld, Leesburg	J. Basil Hall, Tavares	1st Wed.	
**Sumter*				
Lee-Charlotte-Collier-Hendry	Joseph L. Selden Jr., Fort Myers	George D. Hopkins II, Fort Myers	3rd Mon.	
Leon-Gadsden-Liberty-Wakulla-Jefferson	Robert H. Mickler, Tallahassee	Odis G. Kendrick Jr., Tallahassee	Quarterly	
Madison	Candler K. Hayes, Madison	Wilmer J. Coggins, Madison		
Manatee	Richard V. Meaney, Bradenton	Eugene E. Biel, Bradenton	2nd Tues.	
Marion	William J. McGovern, Ocala	Robert L. Gibson, Ocala	3rd Tues.	
**Levy*				
Monroe	Allen Shepard, Key West	William R. Ploss, Key West	1st Thurs.	
Nassau	David G. Humphreys, Fernandina Beach	John W. McClane, Fernandina Beach	Last Fri.	
Orange	Thomas C. Butt, Orlando	W. Ansell Derrick, Orlando	3rd Wed.	
**Osceola*				
Palm Beach	Walter R. Newbern, West Palm Beach	Horace D. Atkinson, West Palm Beach	4th Mon.	
Pasco-Hernando-Citrus	Gail M. Osterhout, Inverness	W. Wardlaw Jones, Dade City	2nd Thurs.	
Pinellas	Percy H. Guinand, Clearwater	Whitman C. McConnell, St. Petersburg	1st Mon.	
Polk	James T. Shelden, Lakeland	Marion W. Hester, Lakeland	2nd Wed.	
Putnam	Bennie J. Massey, Palatka	Bernard E. Kane, Crescent City	2nd Tues.	
St. Johns	Reuben J. Plant Jr., St. Augustine	Roy E. Campbell, St. Augustine	3rd Tues.	
St. Lucie-Okeechobee-Martin	Alfred J. Cornille, Fort Pierce	Adrian M. Sample, Fort Pierce	3rd Thurs.	
Sarasota	Eugene D. Liddy Jr., Sarasota	Karl R. Rolls, Sarasota	2nd Tues.	
Seminole	William V. Roberts, Sanford	Terry Bird, Sanford	2nd Tues.	
Suwannee	Shirley L. Hadden, Live Oak	Hiram B. Curry, Jasper	1st. Sat.	
**Hamilton, Lafayette*				
Taylor			Last Fri.	
**Dixie*				
Volusia	Theodore F. Hahn Jr., DeLand	Achille A. Monaco, Daytona Beach	2nd Tues.	
**Flagler*				
Walton-Okaloosa			3rd Tues.	
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Vol. XLII MARCH, 1956 No. 9

Eighty-Second Annual Meeting
Miami Beach, May 13-16, 1956

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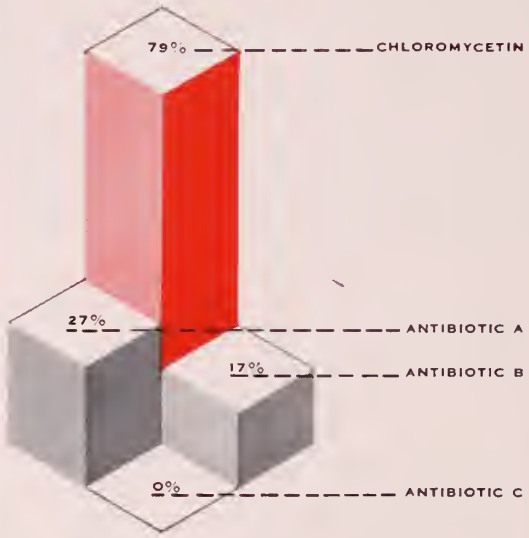
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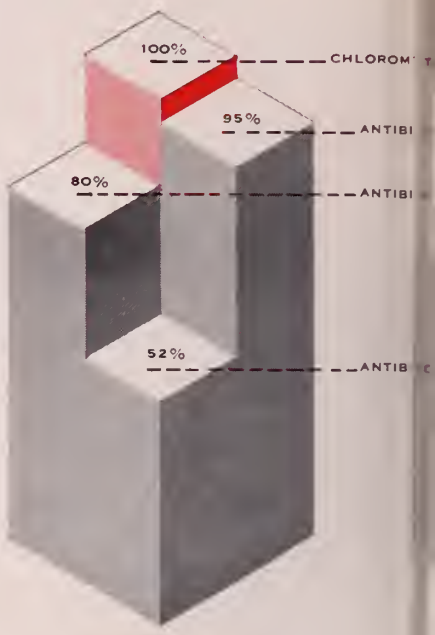
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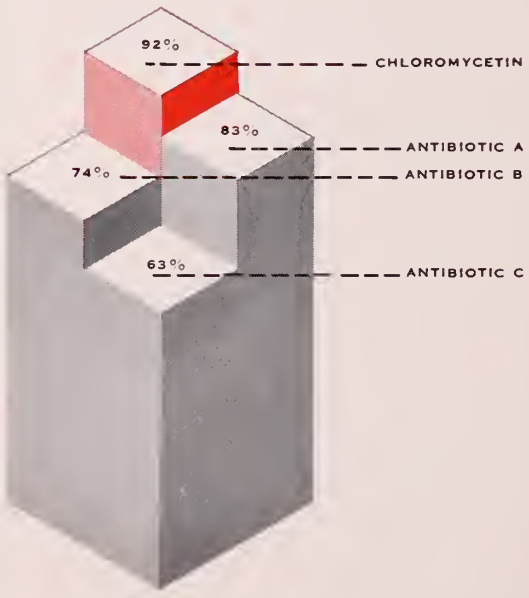
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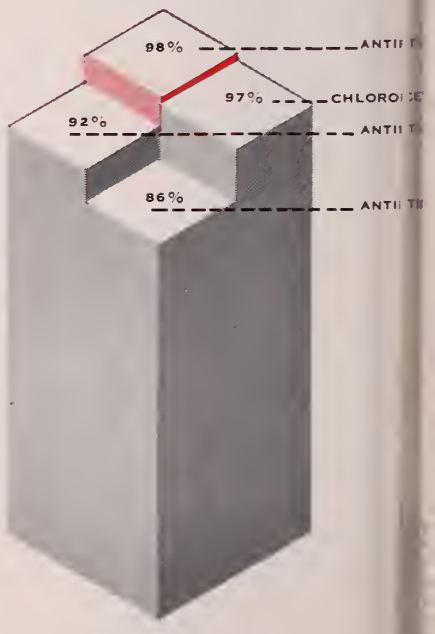
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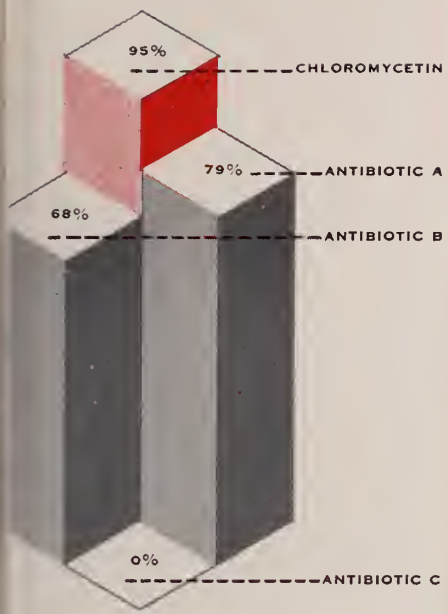
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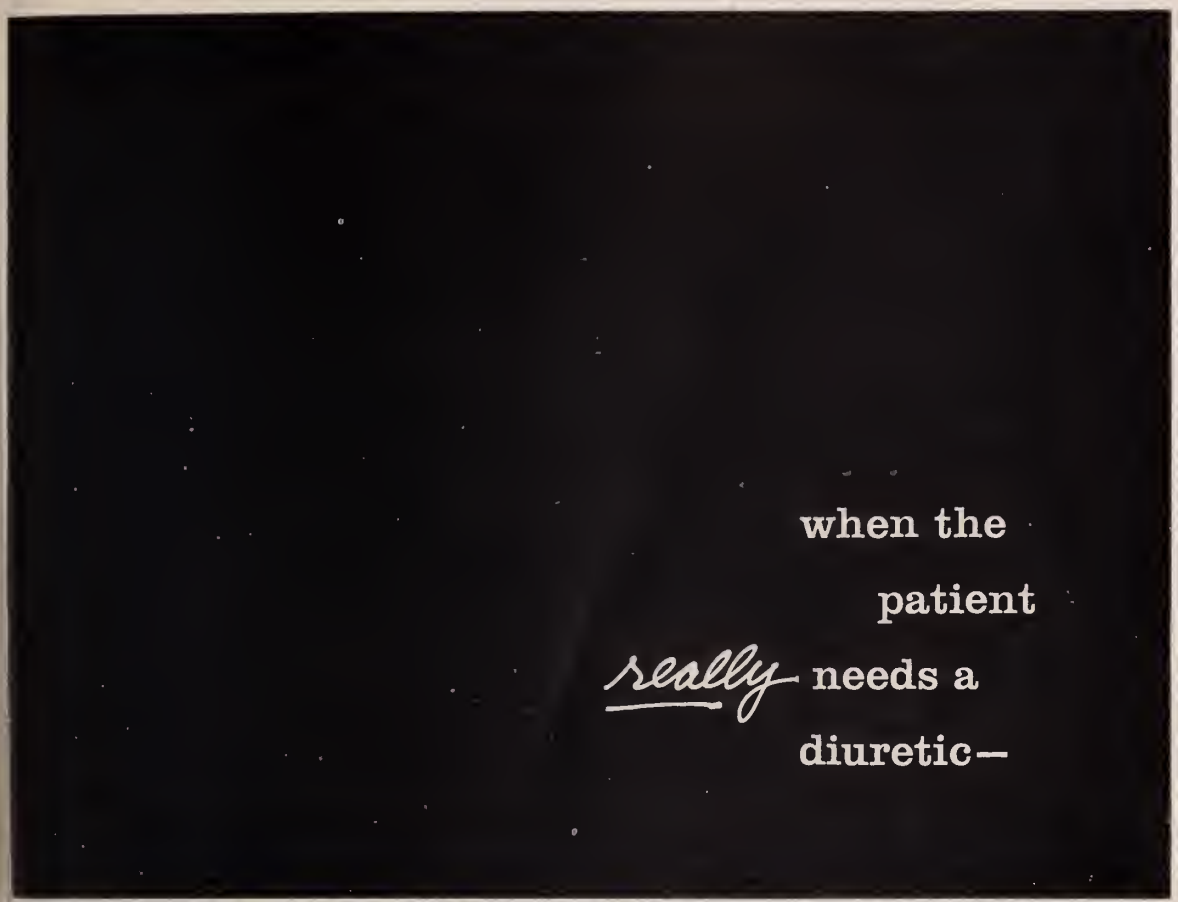
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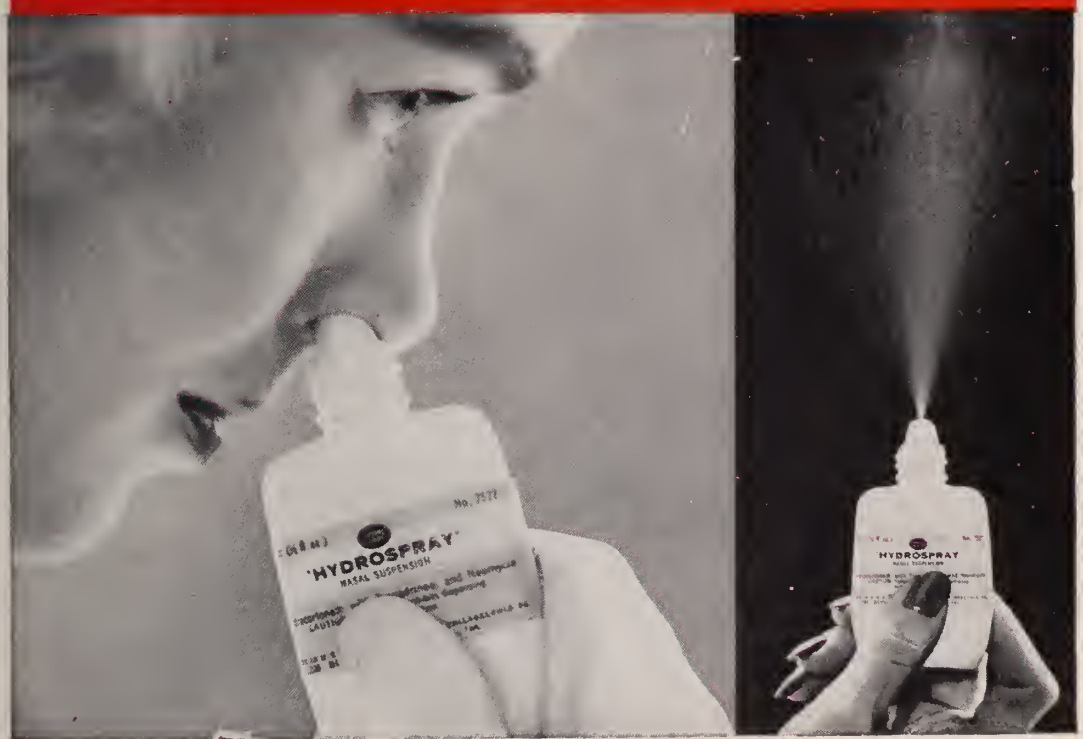
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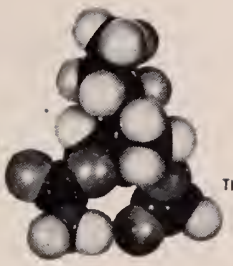
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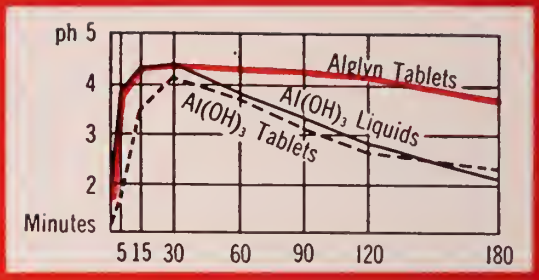
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1. Rossett, N.E. and Rice, M.L., Jr.: Gastroenterology, 26:490, 1954.
2. Hammarlund, E.R. and Rising, L.W.: J. Am. Pharm. Assoc., Scientific Edition, 38:586, 1949.

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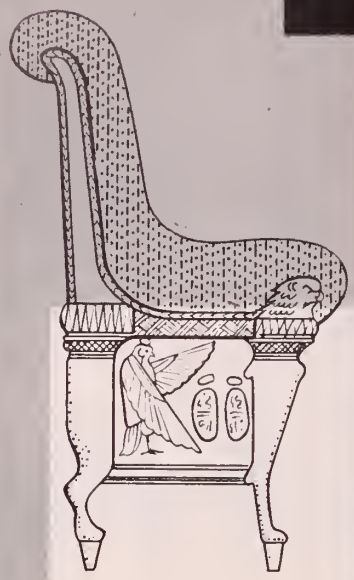
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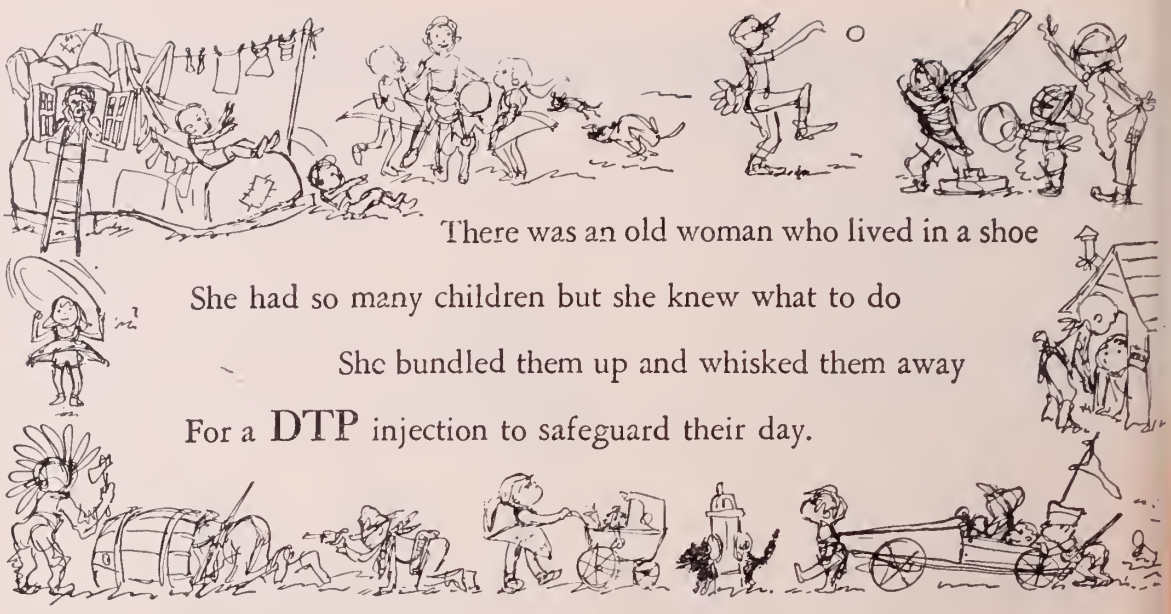
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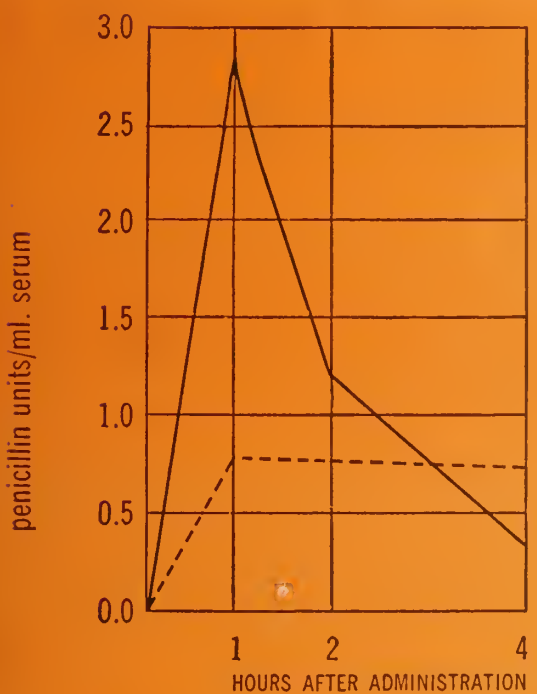
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1. Wright, W.W.: Personal communication.
2. Price, A.H.: Personal communication.

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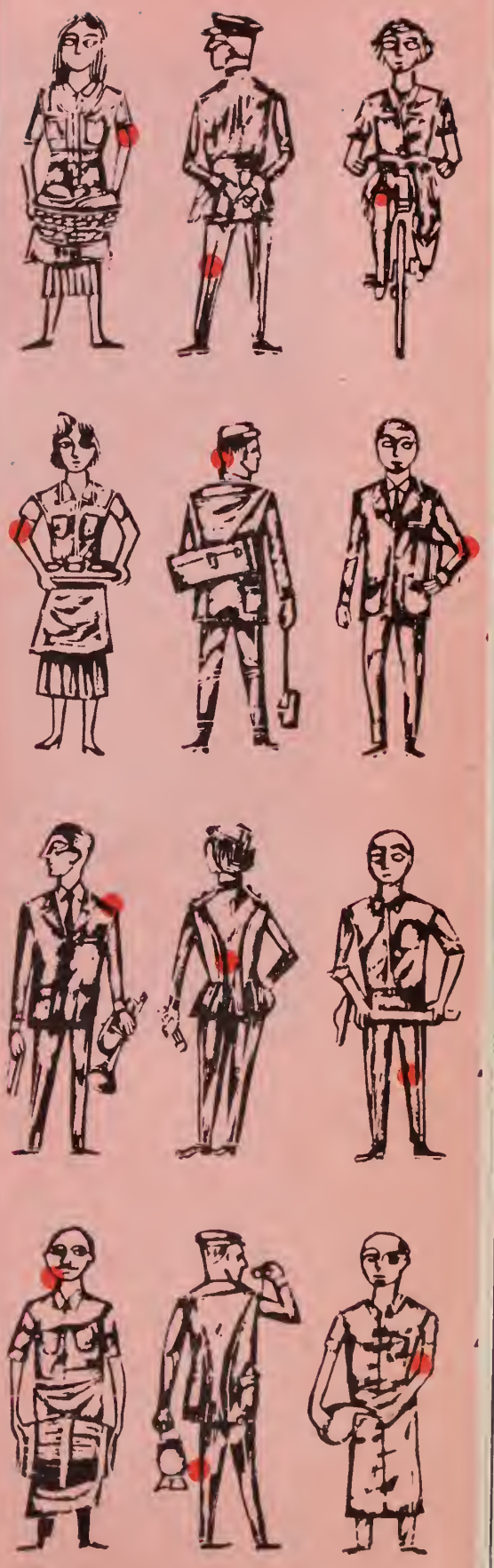
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The Journal of The Florida Medical Association
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Some Applications of Aortography

Ivan Isaacs, M.D.
JACKSONVILLE

My purpose in this presentation is to show how some abnormalities and diseases of the aorta may be accurately diagnosed by special x-ray examinations employing contrast mediums. This has been a subject of increasing importance since surgical procedures are now available to correct some of these abnormal conditions. These aortic lesions are mainly aneurysms, coarctations, and thrombotic occlusions. I will show how a few such disorders have been demonstrated by the various methods of aortography which are available. I cannot take the time to give credit to those who originated these methods of contrast visualization of the aorta, nor can I discuss the technical details of these procedures in the brief time allotted.

The x-ray problem in these cases is to deliver an adequate concentration of a contrast solution into the portion of the aorta which is to be investigated and then to obtain an adequate radiograph. I have used three different methods of opacifying the aorta. For filling of the thoracic aorta, the method of angiocardiography may be employed. A large bulk of contrast solution is rapidly injected into an arm vein, and the x-ray exposure is timed to coincide with the passage of the opaque solution through the aorta after it has gone through the pulmonary circulation. For examination of the abdominal aorta, the more direct method of translumbar aortography is available. The upper portion of the abdominal aorta is punctured with a 6 inch spinal needle, and the contrast solution is injected directly into the aorta. The third method of femoral artery catheterization may sometimes be useful for a particular problem. A polyethylene catheter is inserted into the femoral artery and passed up to any desired level in the aorta. The contrast substance is then delivered into the aorta at that level by injection through the catheter.

From the Department of Radiology, The Duval Medical Center, Jacksonville.
Read before the Florida Medical Association, Eighty-First Annual Meeting, St. Petersburg, April 4, 1955.

Illustrative Cases

The angiocardiographic technic is useful for the demonstration of thoracic aortic aneurysms and for distinguishing such aneurysms from mediastinal masses. Figure 1 illustrates the problem of such an undiagnosed "mass," discovered in this case on a survey chest film. When the interior of this lesion is seen to opacify with the injected solution, it can be positively identified as an aneurysm. Certainly most thoracic aortic aneurysms may be defined without such a contrast study, but the method has been most useful in several cases when the diagnosis was in doubt, or when it was desirable to clarify the origin and extent of an aneurysm for surgical evaluation.

The same method may be useful for study of a coarctation of the aorta, such as is illustrated in figure 2. The diagnosis of coarctation is usually established on clinical evidence and from the well known radiographic feature of rib notching. The exact site of the aortic narrowing and sometimes the length and caliber of the coarctate segment may be shown by angiocardiography. For further study, as in the illustrated case, the method of retrograde femoral catheterization may be employed to define better the distal side of the coarctation (fig. 2C).

Thoughtful planning is essential in setting up the technic which is most likely to demonstrate best the anatomic features of any suspected aortic lesion. The need for this approach is well illustrated by a case in which the anticipated lesion was most unusual (fig. 3). Ordinarily either the translumbar or the retrograde femoral technic would be most applicable for defining a lesion of



Fig. 1.— Aneurysm of Ascending Aorta. Demonstrated by angiocardiography. Negro man, aged 47 years.
A. Asymptomatic mass projecting from right side of mediastinum on plain survey film of chest.
B. Angiocardiogram, 10 seconds after injection of arm vein. Cavity of saccular aneurysm opacified by contrast solution (b). Thick aneurysmal wall, due to laminated thrombosis (a). Verified at surgery, which was unsuccessful.

the abdominal aorta. In this case of hypoplasia of the abdominal aorta, the translumbar method was rejected because of the pronounced calcification in the walls of the aorta. The femoral approach seemed undesirable because the femoral arteries were known to have a greatly restricted blood flow. The angiocardiographic technic was selected as the safest procedure, and produced a reasonably good abdominal aortogram, as it frequently will in thin persons.

For study of occlusions of the lower portion of the abdominal aorta and iliac arteries, and for most aneurysms at these levels, the direct injection of contrast solution into the aorta proximal to the lesion by the method of translumbar aortography is usually the most satisfactory procedure. As in figure 4A, the level and degree of thrombotic occlusion can be visualized in cases of Leriche's syndrome, for the purpose of verifying the diagnosis and planning the possible surgical corrective procedures. Similarly the translumbar method is useful for study of operability of lower aortic and iliac aneurysms, as in figure 4B. What was thought to be an aortic aneurysm in this

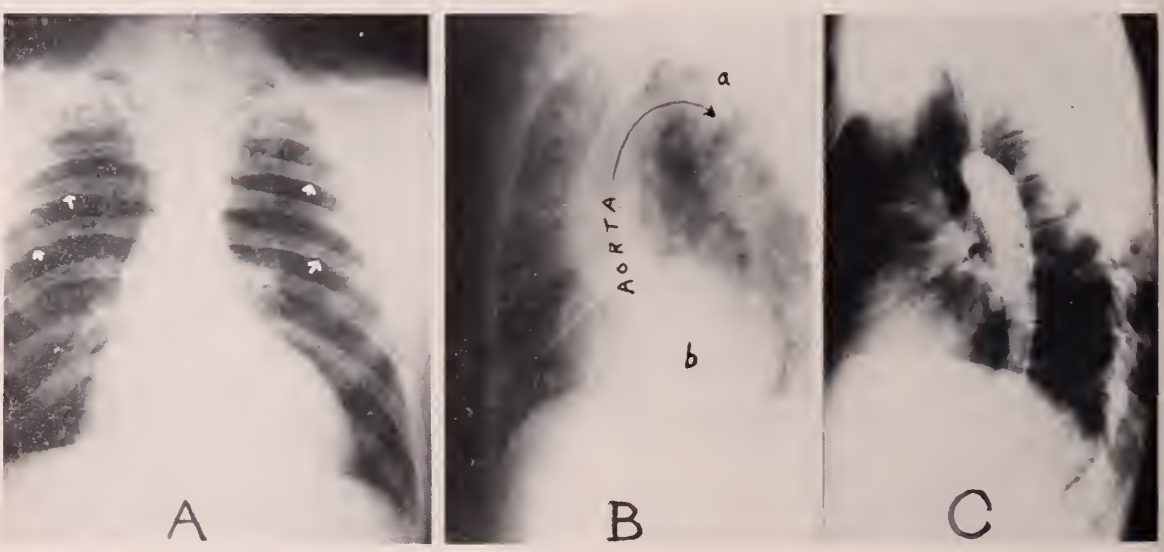


Fig. 2.— Coarctation of Aorta. Demonstrated by angiocardiography and retrograde femoral aortography. White man, aged 38 years. Hypertension in arms; no pulsation of arteries in the legs.
A. Conventional chest film. Enlarged heart. Notching of ribs.
B. Angiocardiogram, exposure 8 seconds after injection, demonstrating the usual type of coarctation, occurring just distal to the dilated left subclavian artery (a). Large left ventricle (b), and dilated aortic arch, well opacified, with abrupt termination at coarctation (arrowhead).
C. Retrograde aortogram with catheter passed into the aorta from the femoral artery. Abrupt termination of the well opacified aorta at a point closely corresponding to the proximal side of the coarctation shown in B, indicating a short coarctate segment.
Verified at surgery as a complete closure of the aorta at this level.

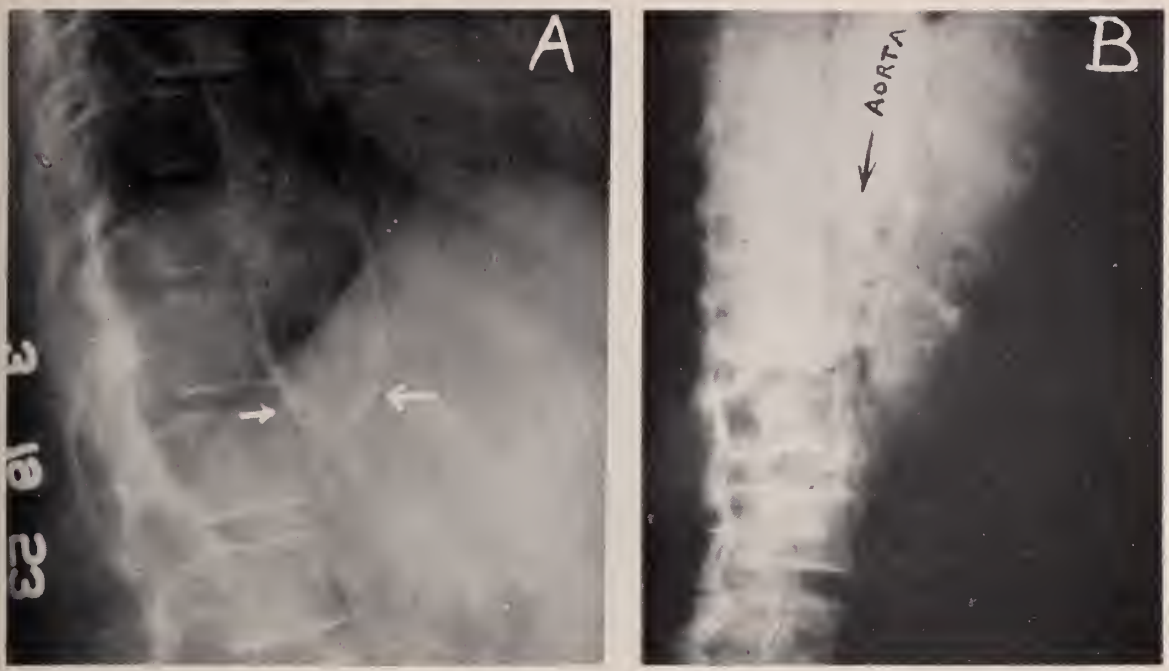


Fig. 3. — Hypoplasia of Abdominal Aorta. Demonstrated by angiocardiography. White woman, aged 34 years. Intermittent cramping and numbness in legs for years. Also abdominal cramps and vomiting. Blood pressure not obtainable in legs; 165/90 in arms. No femoral pulse.

A. Plain lateral film showing pronounced calcification in the walls of the lower portion of the thoracic aorta. The aorta, as outlined by the calcium, begins to narrow (arrows) just below the level of the diaphragm.

B. Angiocardiogram (slightly retouched), showing opacification of the lower thoracic and upper abdominal portions of the aorta, 6.5 seconds after arm vein injection. There is a conical narrowing of the upper part of the abdominal aorta to an extremely narrow long channel. Other film area, not reproduced, showed blood supply of the iliac arteries via the collateral system of the internal mammary and inferior epigastric arteries.

This case considered inoperable by consultant vascular surgeons.

case was actually determined to be an aneurysm of the right common iliac artery. An additional study by retrograde femoral catheter technic was performed (fig. 4C) in order to define the extent of the iliac aneurysm more completely.

Figure 5 illustrates a case of multiple aneu-

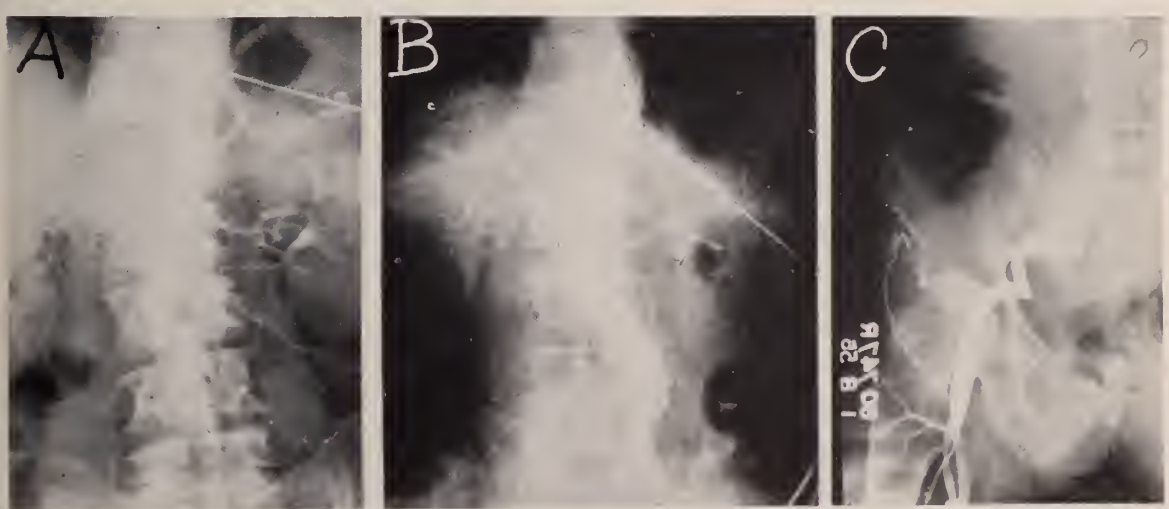


Fig. 4. — Translumbar Aortography.

A. Leriche's Syndrome. Thrombotic occlusion of lower portion of the abdominal aorta. White man, aged 64 years. Severe claudication. No pulsations in distal vessels of the legs. Translumbar aortogram shows obstruction of the aorta a short distance above the bifurcation. Refused surgery.

B. Aneurysm of Right Common Iliac Artery. White man, aged 65 years. Abdominal pain for two years and tender pulsating mass. Exploration at a small rural hospital revealed aneurysm. Referred for study prior to attempted resection. The translumbar aortogram shows nonvisualization of the right common iliac artery.

C. Same case as B. Retrograde right femoral catheterization. Verified diagnosis of right iliac aneurysm by partially filling the sac with opaque solution



Fig. 5.—Aneurysms of Abdominal Aorta and Iliac Arteries. White man, aged 64 years. Painful pulsating mass in midabdomen. Retrograde femoral catheterization studies.
A. Aneurysm of right common iliac artery.
B. With catheter further advanced, a diffuse aneurysmal dilatation of the terminal aorta is shown.
C. With catheter in left femoral artery, a similar aneurysm of the left iliac artery is opacified.
Surgery not attempted in January 1953, but might be feasible with newer graft technics.

rysms involving the lower portion of the abdominal aorta and both common iliac arteries. This study, performed a few years ago, utilized the retrograde femoral catheter technic on both sides. In the light of more recent experience, the less tedious translumbar method might just as well have been employed.

Summary

In certain pathologic conditions of the aorta, it is usually possible to demonstrate clearly the true nature and extent of the lesion by the methods of aortography described. The surgeon may then come to a decision as to the operability of the patient and the type of surgical procedure to be employed. With increasing surgical experience in the correction of these disorders, preoperative aortography may not be necessary in all cases, but at the present time my surgical colleagues are finding these aortograms most helpful. I think radiologists should continue to try to improve these radiographic technics just as the surgeons are endeavoring to perfect their operative procedures.

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Discussion

DR. C. BURLING ROESCH, Jacksonville: I want to say a few words in tribute to Dr. Isaacs' energy and initiative in getting together these cases for your consideration this afternoon. The main point I wish to stress is that these technics are not necessarily confined to cities like Jacksonville, Miami and Tampa. They can be performed in any hospital that has a good x-ray machine, an enterprising roentgenologist, and an accommodating surgeon who can cannulate the arteries as necessary. I have been fortunate to be associated with Dr. Isaacs in some of these cases and I assure you that although we cannot go into detail about our technic, it is really quite simple. It just takes a little initiative.

When Dr. Isaacs came to Jacksonville, we had been trying vainly to get some of the roentgenologists there to take up aortography, but there was always one objection or another. We even went to the Board of Health one day with a patient with a thoracic aneurysm and tried to take some pictures on a photofluoroscopic screen there, but the attempt did not work out too well. When Dr. Isaacs arrived in the city, with the aid of a carpenter at the hospital and a little bit of lead and a stop watch he made a cassette tunnel and a panel to push plates through. He then trained a staff to assist him, and we began getting good pictures. The cases presented are typical of many around the state, not only in large cities. Most of the patients in these cases came from outlying districts of Jacksonville, but all over the state there are many, many cases which could be diagnosed positively and appraised for surgery, or in numerous instances we could save patients a long trip to a larger center where we have more facilities if we knew ahead of time what they presented. All it takes is somebody with the intelligence and initiative and energy that Dr. Isaacs has shown. I would urge that everybody who is interested in this problem go back and try to set a little fire under their local roentgenologist, because it can be done if one is interested.

DR. FRANCIS N. COOKE, Miami: I have certainly enjoyed this presentation by Dr. Isaacs. It is the roentgenologist's contribution in this field that has made the role of the cardiovascular surgeon considerably easier. I

should like to show a few slides demonstrating some of the points that Dr. Isaacs has mentioned. This slide shows an aneurysm of the abdominal aorta. In the interpretation of these aortograms, you will note that the concentration of dye in the aorta proximal to the aneurysm is good. The fact that the dye sometimes is not seen at the aneurysmal sac does not mean that the aneurysm is not there. In this patient the aneurysm is easily visualized, but there is considerable dilution of the dye as the stream hits the large pool of blood which is surrounded by this false sac. In addition, I think you can see calcification in the wall of the sac and clot in between that calcified wall and the lumen.

This slide shows another aneurysm in a 71 year old man causing considerable pain. Again you see the dye in the lumen of the aneurysm, but there is a considerable portion of the aneurysm to this side of the dye, and that is laminated clot. It was a large aneurysm, fully as large on the side toward me as on the right side. This aneurysm was removed and the defect bridged with an homologous graft. Here is another aortogram, and the aneurysm, although faintly seen in this aortogram, was also of moderate size. These aneurysms characteristically arise below the renal vessels. Nevertheless, it is of some comfort to be able to visualize them radiographically. In this slide showing a section of the aneurysm just seen, you will notice the left renal vein at the top of my light; the aneurysm arising below the renal vein. The left renal vein seems to act as a barrier to spread of the aneurysm upward. This aneurysm was also excised. This slide shows the graft in place. As seen here, the graft seems to fit well; it was under a little tension, as it should be. This is a postoperative aortogram of that same patient. The host vessel is larger than the graft. The graft, which is taken from a young person, is usually smaller than the host vessel. There is undoubtedly some shrinkage of the graft in the process of quick freezing and storage. Pedal pulsations in this patient, however, are extremely good and his symptoms have been entirely relieved.

In this slide, we see demonstrated a Leriche syndrome or idiopathic obliteration of the terminal portion of the aorta. Here you see the clot at operation completely thrombosing the aorta in a 53 year old man who was incapacitated for five years. Vascular continuity was reestablished with an homologous graft. This man now is back at work for the first time in five years.

This slide shows another patient who has a Leriche syndrome. You can see from the aortogram that the dye stops just at this point. Look at the beautiful collaterals that have developed in this patient, a 40 year old man. In this instance a graft replacement of the thrombosed segment would be comparatively easy. Once this thrombotic process reaches the renal vessels, it is, of course, incompatible with life.

I have certainly enjoyed Dr. Issacs' paper. These advances in radiographic technics are of tremendous advantage to all interested in the diagnosis and treatment of these disease processes.

Preventive Pediatrics

David W. Martin, M.D.
West Palm Beach

First, I want to thank you for the privilege of being here this morning. Second, I want to congratulate you on the great work you have done in improving and expanding the public health units throughout the state.

As a pediatrician I have always been proud of the part pediatrics has had in initiating and promulgating preventive medicine. It is becoming more imperative as we go along that there be cooperation between the pediatrician and health officers. We are fortunate in Palm Beach County to have a capable and most cooperative Director of the County Health Unit in Dr. Clarence L. Brumback and a group of pediatricians who are willing to work together with him. I should like to discuss with you some of the programs that have been initiated through this cooperation, a few of the thoughts of pediatricians for the future, and perhaps a few objectionable features not in the way of criticism but in the hope of benefit to you and ultimately the public.

In 1951 at the suggestion of Dr. Brumback the pediatricians of West Palm Beach agreed to start a Negro well baby clinic with sessions one day a week. This project has been most successful, and this last year 175 babies were seen. We as a group are unanimous in the opinion that since its onset we are definitely seeing fewer sick Negro infants requiring hospital care and consider that time given to these clinics has actually saved us many hours of our time. The success of this project, however, is dependent on the time and effort of the public health nurses who have patiently followed up the instructions of the pediatricians in educating the mothers in the care of their infants. From my experience in the past and present, I think well baby clinics under sponsorship other than health departments are unsatisfactory.

Immunization

Immunization procedures are an important concern of both the health officer and the pediatrician and unfortunately not infrequently a bone of contention. Personally I find there are few of my patients who can afford to pay for immunizations who take advantage of "free shots," as they are called. Also, I think that perhaps our charges

Read before the Florida Health Officers' Society, Tenth Annual Meeting, St. Petersburg, April 4, 1955.

for these procedures are out of line at times.

The schedule for administering the combined diphtheria-tetanus toxoids and pertussis vaccine is probably best started when the child is 2 to 4 months of age with three injections one month apart followed by a booster dose at yearly intervals, certainly every two years. After the child reaches 8 years of age, only tetanus booster doses are advisable.

Smallpox vaccination is best given in the first few months and repeated at five year intervals.

The administration of typhoid vaccine is advisable after the first year, and it may be given intradermally in the initial series with little reaction. Booster doses may be given each year.

Certainly we all have hope that polio vaccine is effective and that its use will become a routine procedure.

One of the sore points between us in regard to immunizations stems from the public health nurses' ignorance of contraindications to these procedures. Few occurrences will make a pediatrician "boil" quicker than to see a child with eczema vaccinated or to see a child receive his second injection of diphtheria-tetanus toxoids and pertussis vaccine in full dose after having a severe reaction to the first dose. Vaccination should not be performed on a child with eczema, or if a child in the household has eczema. An infant who has temperature over 101 F. from a previous injection of this immunizing agent should not receive the full dose with the second. The hard slow-absorbing nodules following its injection can be eliminated by the simple ritual of wiping the needle on the alcohol sponge and injecting deep into the muscle.

Immunizations are probably contraindicated in children over 1 year of age when a polio epidemic is present.

Preschool and school examinations provide another wide field for prevention that requires cooperation between us. My opinion is that the present program of preschool examination under the Parent-Teacher Association round-up is worthless or nearly so, and occasionally detrimental because it reassures the parents when no assurance is justified. To ask any physician to examine 30 to 50 children in two or three hours and do them justice is ridiculous. The whole program should be taken away from lay groups and a practical program worked out with the Health Unit and local physician. I am sure the practicing pediatrician will cooperate with any plan that he thinks will benefit the community and its children. Most parents would prefer to consult a private physician and pay for services. Those who are screened by the Parent-Teacher Association as unable to pay would be examined without charge by a panel of doctors in their own offices where an adequate history may be taken and diagnostic tests may be performed. In the school program the teacher should be authorized to require medical consultation for those children who do not appear well or have difficulty adjusting to school discipline. This objective is being accomplished to a small extent in our locale at present in a roundabout way. Many of the teachers are referring their problem children to the new Palm Beach County Child Guidance Clinic, and Dr. Joanna Byers, the Director, wisely requires a medical work-up before the consultation. It is interesting to note that of those referred to me only about one third have required psychologic consultation since the cause of their behavior problem was found to be physical.

Accident Prevention

The latest field of prevention in which the pediatrician has become interested and which interests health officers also is accident prevention in children. A few years ago the Academy of Pediatrics in cooperation with the Metropolitan Life Insurance Company started a study of accident prevention. I must confess at first the subject and chances of worth while accomplishment looked dull to me, but as we were deluged with more and more facts and information, I have become much interested and can see great possibilities. One cannot be disinterested when he hears that 12,000 to 13,000 children are killed by accident each year, with 40,000 to 50,000 permanently injured, and that at least one million seek medical care each year because of accident. At first glance the problem seems impossible to solve, but as we analyze the figures, it is simplified. Half of all fatal accidents occur in the preschool group, and since accident prevention is dependent a great deal on education, if we concentrate on the 1 to 5 year age group as they mature, the older age group is taken care of.

Further, the principal causes of fatal accidents in this group are only five in number — drowning, burns, conflagration, falls and poisonings. The peak incidence of fatalities from all these causes falls in the age group between 1 and 2 years. This finding provides basic material on which to work. The first year of life the infant

is defenseless and must be given 100 per cent protection from burning, crushing, drowning, poisoning and falling, which is relatively simple. The years from 1 to 5 must be occupied by diminishing protection and imaginatively, bravely, increasing educational experience. Three tools are indispensable — forethought, a prediction based on age, and observation of interests and abilities which should indicate what protective measures are necessary and in what areas of activity. Instruction will keep the child out of serious accident. Discipline is necessary not only to his physical safety but to his mental security as well, and how better may a parent spend his time? These points we are trying to get across to the parents of children we see for well baby check-ups and routine visits. The number we see, however, is too small. We need the help of the health officers and the community as a whole. An accident prevention program should originate with the health officer and the pediatrician with a well formulated plan.

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Three Physiologic Modifications of Stroke

C. MacKenzie Brown, M.D.
TAMPA

Although an etiologic classification is preferable when one considers congenital hemiplegia, head injury, vascular accidents, neoplasms, infection, miscellaneous conditions and hysteria, it may be helpful to carry in one's memory the short form "EATIT" — "E" for embolism, "A" for apoplexy, "T" for thrombosis, "I" for inflammation or abscess, and "T" for tumor. When the onset of symptoms is slow, the cause is usually in the right part of "EATIT" and when the onset is rapid, the cause is usually in the left part of "EATIT." When neurogenic shock is present, the more pronounced it is, the farther the cause shifts to the left in "EATIT."

It must be emphasized that an accurate diagnosis should be established before one considers the use of homolateral stellate block[1] compared with contralateral stellate block and posterior root neurolysis in the management of "stroke" patients.

Once a diagnosis of embolism or thrombosis or apoplexy which has ceased to hemorrhage for a week has been made, I have performed a homolateral stellate block by the anterior approach (fig. 1). This therapeutic cervicothoracic sympatholytic procedure may modify cerebral function so that improvement is often dramatic, beginning within a few minutes of the production of Horner's syndrome. Many workers[2] have demonstrated the overlap of somatic and autonomic representation in the premotor cortex. Such representation makes cervicothoracic sympatholysis a logical procedure. The use of stellate block[3] also is based upon its action of interrupting impulses that may lessen the blood supply to adjacent and even remote

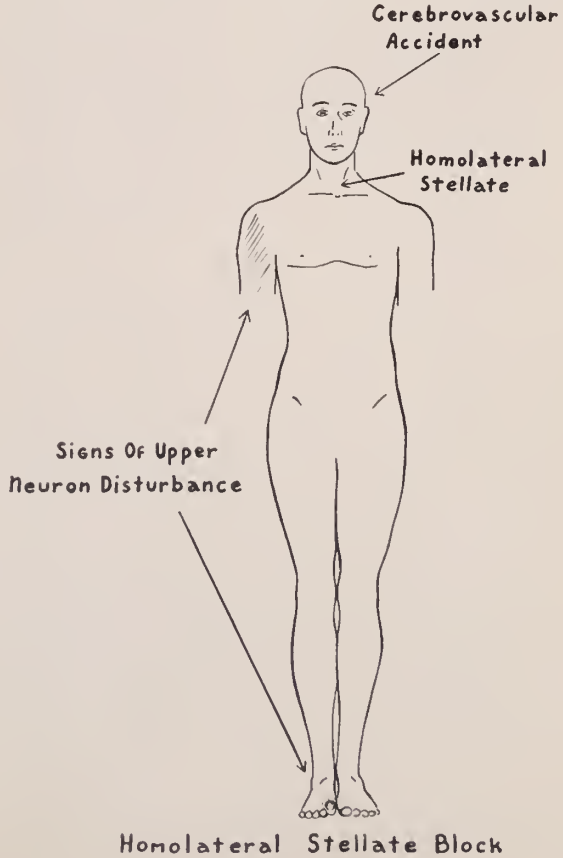


Figure 1.

Read before the Florida Heart Association, Seventh Annual Meeting, St. Petersburg, April 2, 1955.

parts of the brain after a "stroke." Thus is explained the often wide variation between the clinical course of the disease and the less involved change in the brain morphology at final examination. When such impulses are not interrupted, hypoxia of a larger portion of the brain occurs than that endured at the site of the initial cerebral embolism, hemorrhage or thrombosis. Lack of oxygen causes cerebral edema, and thus a vicious circle may be established.

There are some reports in the medical literature which are not enthusiastic about this therapy, but the overwhelming majority of medical reports agree with my experience. Not all cerebrovascular accidents are helped by stellate blocks. In those cases refractory to sympatholysis probably there is too far advanced cerebral arteriosclerosis or too much cerebrolysis.

During the last 10 years I have witnessed hundreds of patients with hemiplegia,[1] aphasia and/or dysarthria who, within a few minutes after Horner's syndrome developed, were able to move previously immobile limbs, were able to talk and became mentally alert. As a rule the leg function returns more easily than the arm function, and the arm function more easily than the relief of aphasia.

It is usually necessary to perform a series of stellate blocks in order to create a continuous sympatholysis. During the first 48 hours I suggest a stellate block every eight hours with Pontocaine (0.15 per cent) and thereafter once daily for a week. This procedure should be employed at the earliest possible moment and in properly selected cases.

In "strokes" there is often considerable vasomotor disturbance in the affected extremity due to sympathetic imbalance. The hand may be red and swollen because of this disturbance rather than because of immobility alone.[5] In some of the old hemiplegic patients it may be better to block the contralateral stellate ganglion (fig. 2), particularly if the homolateral stellate block has not been effective eight hours previously.[6]

It is difficult to attribute the improvement to anything other than neurophysiologic change consequent to sympathetic paralysis, particularly so when a patient has remained in a static condition for a number of days, weeks or months and then improves for the first time after a stellate block.

Nerve block therapy may be affected by another physiologic modification; sometimes worse than the paralysis is the intolerable pain of the arm or other part which may grip the "stroke" victim. Some believe the cause of such intractable misery is in the sensorimotor area of the brain.

In October 1954, I saw Mr. W. of Birmingham, Ala. He had had a "stroke" three years previously involving the right hemisphere. When he was referred to me, he was suffering with intolerable pain and "clamping down" of the left hand. Even after several stellate blocks and other therapeutic procedures were tried, no satisfactory relief of pain occurred in his case. Only after subarachnoid absolute alcohol neurolysis of the posterior roots of the brachial plexus (figs. 3 and 4) on the left side (under orotracheal anesthesia for five hours) did this patient obtain relief of pain. His serious narcotic habit was broken. At the last examination on March 25, 1955, he still had complete relief of pain in that extremity.

Other Therapy

These three physiologic nerve block modifications are only part of the necessary therapy for "strokes," although a most important part. Oxygen therapy of course should be used in all cases. When auricular fibrillation is present, an attempt should be made to control it. When cerebral embolism is present, anticoagulant therapy is begun after phenol block of the stellate ganglion, not before. In "stroke" patients with hypertension,

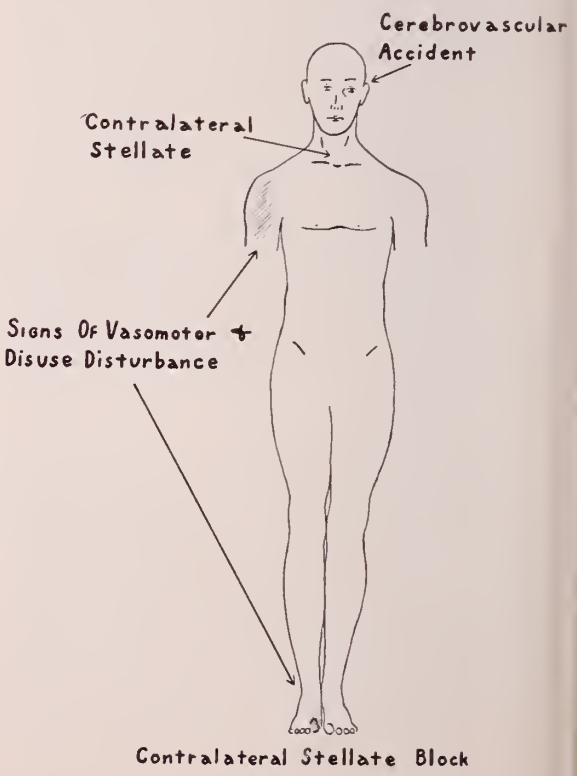


Figure 2.



Subarachnoid Absolute Alcohol Neurolysis Of The Posterior Roots Of The Brachial Plexus On The Left Side

Figure 3.

it may be well to resort to venesection and also to remove some spinal fluid slowly in order to decrease safely the markedly increased pressure which often results. Hypertonic intravenous solutions may be beneficial. Physical therapy is an important adjunct in most of the cases.

If optimal results are to be obtained, the physician must utilize the ability of his colleagues, when indicated, in psychiatry, orthopedic surgery, neurosurgery, internal medicine and anesthesiology. Thus an increasing percentage of patients treated will be grateful for their return to a useful comfortable life.

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Posterior Root of Brachial Plexus



Position of Posterior Root During Subarachnoid Alcohol Block

Figure 4.

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Florida Medical Association

Eighty-Second Annual Meeting

The program for the Eighty-Second Annual Meeting of the Florida Medical Associaton, being held May 13-16 in the Hotel Fontainebleau, Miami Beach, will be published in detail in the April issue of The Journal. Previously the program appeared in the March issue. This year, however, the meeting is scheduled one month later than usual.

Simplified Method for Evaluation of Left Suprarenal and Gastric Masses

BENEDICT R. HARROW, M.D.
MIAMI

An increasing number of patients with hypertension are being studied for the possible presence of a pheochromocytoma or unilateral renal disease. One of the diagnostic tests usually performed is an intravenous urogram for the detection of a damaged or displaced kidney or for the presence of masses in the adrenal area, although most pheochromocytomas are too small to visualize on the intravenous pyelogram. Frequently a well delineated mass is seen at varying distances above the left kidney, but it is well known that in most cases this roentgen finding represents a collapsed stomach. This roentgen density may persist in the same size, shape and position on subsequent roentgenograms. It may persist even when roentgenograms are taken with the patient in different positions. It is, therefore, common practice to perform presacral gas injections in order to prove whether such a shadow represents an actual retroperitoneal tumor.

It is much simpler to interpret the left suprarenal shadow by giving the patient orally 6 to 10 ounces of a carbonated beverage, which releases carbon dioxide rapidly and greatly distends the stomach. The suspected suprarenal mass then usually disappears and obviously had represented a collapsed stomach. The carbonated beverage can be given just before the late upright film for renal ptosis; thereby, no additional films other than those used in the routine intravenous pyelogram need be consumed.

Presacral air insufflation is an excellent diagnostic procedure, the value of which is greatly increased when it is used with laminography.[1] Because, however, the initial reports on small series emphasized the simplicity without complications, it is sometimes being performed carelessly without regard to inherent dangers. With this procedure gas embolism and retroperitoneal infection with fatalities have been reported;[2-4] it therefore should be used only when deemed necessary. The gas should be injected with aseptic technic slowly at low pressures, and it might be best to use the gas which is most dissolvable in tissue fluids, carbon dioxide. In case embolism occurs, the physician must be fully aware of the available methods of treatment, especially the left decubitus position.[5,6] The mere presence of the mass above the left kidney is not enough indication for gas injection unless this lesion persists after the stomach is dilated with carbon dioxide. The presacral insufflation should by all means be used in selected patients if other clinical evidence is obtained from the history,[1,7] from pressor and sympatholytic agents,[8] high blood sugar, peripheral vasospasm, elevated basal metabolic rate, increased urinary catecholamines,[9] or other masses on the intravenous pyelogram.[10] It is neither feasible nor safe to perform presacral injections at random on hypertensive patients.

Figure 1 is a 15 minute urogram in a 70 year old hypertensive woman. Above the left kidney is a mass which was persistent on all the films and is seen to overlay the medial surface of the spleen. On the late upright film for ptosis after a Coca Cola (fig. 2) the stomach is clearly visualized with a disappearance of the preceding mass, demonstrating that the "tumor" was an empty stomach. The spleen, the tip of which was palpable only with lateral positioning, is clearly seen with the notch and medial border visible.

Other investigators have demonstrated the great usefulness of carbon dioxide in visualizing more adequately the kidneys of children.[11] In adults the left renal outline becomes clearer when the stomach is distended, but only occasionally has this been of any value.

For the detection of carcinoma of the stomach I have been using as a routine procedure 6 to 10 ounces of a carbonated beverage taken orally by the patient just before the late upright film for renal ptosis. This type of film will detect only a very large, fungating, polypoid lesion or one producing a very large ulceration. Although large, this type of tumor may not metastasize until very late[12] and therefore is resectable and

From the Department of Urology, Mercy Hospital, Miami.



Fig. 1.— A mass is demonstrated above the left kidney in this 15 minute intravenous urogram in a 70 year old hypertensive woman.

possibly curable. By the time a polypoid tumor produces symptoms, it is usually massive and then is inoperable because of extension into neighboring structures. With this technic it is estimated that only one out of 2,000 intravenous pyelograms performed in persons over 45 would demonstrate a lesion. Tremendous numbers of intravenous urograms are performed daily by general practitioners and specialists. If each used this procedure, which costs only five cents, then a few more asymptomatic or unsuspected neoplasms of the stomach could be discovered. It is obvious that many lesions, especially those of the anterior and posterior walls, will be missed and that the carbon dioxide method does not compare even with the controversial screen testing using photofluorography. Nevertheless, an opportunity is present to find an unsuspected, asymptomatic resectable carcinoma, and it is incumbent upon every physician to detect carcinoma at every chance. Other lesions such as diaphragmatic hernias, diverticula or polyps may be detected during this study. Of course carbon dioxide distention has been used since 1900 by radiologists and in more recent years for double contrast studies, but never as a routine during urography.[13]

Figure 1 also shows that intravenous urograms can be as satisfactory as retrograde pyelograms in a large percentage of patients. Even in older persons and in some patients with diminished renal function, good filling and contrast can be obtained provided adequate compression to 110 or 120 mm. of mercury is utilized properly. Either Balsa blocks or rubber bags are effective and have to be used only two to three minutes if applied to the proper degree of pressure by gaining the confidence of the patient and keeping the pressure at this constant high level during the entire two to three minutes. The trick in obtaining adequate compression is the constant tightening of the compression band during the entire two to three minutes since any one of the respiratory movements may suddenly loosen the band in a matter of a few seconds.[14,15] With proper technic it is not rare to visualize streaks of contrast substance in the tubules of the papillae.

Summary

If a persistent left suprarenal roentgen shadow is discovered on an intravenous pyelogram during the study of a hypertensive patient, it is not necessary to utilizé presacral gas injection immediately. Carbonated beverages should first be used orally to distend the stomach. Most of the time the roentgen shadow represents a normal, empty stomach and disappears when the stomach is distended with carbon dioxide. Presacral gas injections may result in fatalities from embolism or infection and should be performed with extreme care and only when definite indications exist. At present many physicians use the procedure without regard to its inherent dangers.

By distending the stomach with carbon dioxide before taking the upright film for renal ptosis during intravenous urography, one can discover an occasional fairly large gastric carcinoma that is still resectable and possibly curable.

The value of the intravenous urogram itself can be increased by the use of adequate compression for only two to three minutes with constant tightening of the band.

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Fig. 2.— After ingestion of a carbonated beverage, the stomach is clearly visualized on the late upright film for ptosis, with a disappearance of the mass shown in figure 1 demonstrating that the "tumor" was an empty stomach.

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Changing Problems in the Bacteriologic Diagnosis of Tuberculosis

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There have been amazing changes in the field of tuberculosis. Looking back to the twenties and thirties when many of us received our introduction to medicine, this was a disease which offered little to challenge the interest of medical students. The knowledge of this chronic infection seemed fixed and unchanging, and there appeared little to be done in treatment beyond providing weak and often ineffective aid to nature's slow healing processes. During recent years, however, the medical treatment of tuberculosis has been transformed and surgical treatment developed, and effective control measures are being applied widely. Mortality is declining rapidly, and those who look to the future are beginning to think in terms of eradication. The many changes in clinical and public health practice in tuberculosis have brought new and modified problems to the laboratory. Hence, attention is invited to the "Changing Problems in the Bacteriologic Diagnosis of Tuberculosis."

The outstanding and most urgent laboratory problem in tuberculosis today is the need for more sensitive bacteriologic technics. It has been estimated by Corper and Cone[1] that a positive microscopic diagnosis can reasonably be expected only when there are at least 100,000 *Mycobacterium tuberculosis* bacilli per milliliter. The more sensitive culture examinations will be positive when there are fewer organisms, but it must be assumed that a negative culture at present means only that there are less than 50,000 or 25,000, or possibly as few as 10,000 of these organisms per milliliter. The less sensitive procedures were reasonably adequate to aid in diagnosis when patients sought care for troublesome symptoms at a time when they ordinarily had manifest physical signs. The stained smear would readily reveal the presence of acid-fast organisms in the sputum in most cases of this type. Today, it is different. The present objective is to detect infection before there are either symptoms or physical signs, and this is being accomplished with gratifying success by case-finding activities. Highly sensitive laboratory procedures are required for the bacteriologic diagnosis in these early cases. Moreover, in treatment, organisms persist and are discharged presumably for some weeks after present cultures cease to be positive. In the guidance of continuing therapy, it would be helpful to know the antibiotic sensitivity of these residual organisms. Furthermore, the public health control of tuberculosis would be much better if open cases could be detected when only small numbers of organisms were being discharged. The importance of more sensitive laboratory tests cannot be overemphasized.

The microscopic examinations of stained smears have provided results obtained by a constant procedure. Changes in these findings over a period of years, therefore, reflect changes in

Director, Bureau of Laboratories, Florida State Board of Health.

Read before the American College of Chest Physicians, Florida Chapter, St. Petersburg, April 3, 1955.

the character of the material being tested. The proportion of specimens found positive by smear in the Board of Health's Jacksonville Laboratory declined from 13 to 10 per cent between 1948 and 1952, but in the next two years this decline fell from 10 to 5 per cent. The practical value of the diagnostic smear is changing since at present most of the specimens positive by smear are positive also by culture. During the past year, the proportion of positive specimens was increased by less than 1 per cent by the tedious and time-consuming smear examinations. When this test fails to reveal any significant number of added positives, it will need to be decided whether the early report of a limited number of positive findings by smear examination justifies the cost of this extra test.

Since 1948, all specimens submitted to the Jacksonville laboratory have been cultured. There has been a clearly evident progressive increase in the sensitivity of this test. During 1948, only 10 per cent of the specimens were positive by culture, but there was a steplike increase in the following three years to 11, 14 and 17 per cent positive by this procedure. During the same period, the proportion of specimens found positive by smear declined from 13 to 10 per cent. If there had been no change in culture technics it would be assumed that the positive findings by culture would have dropped also from the 10 per cent in 1948 to about 8 per cent in 1951. Actually, however, 17 per cent instead of 8 per cent of the specimens were found positive by culture in this later year. Thus, the yield in positives by culture, and hence the sensitivity of the culture test as applied, was more than doubled during this period. Since the culture procedure is the most sensitive bacteriologic technic now available, superior even to animal inoculation, the factors causing these observed variations in results need to be examined.

Factors Causing Variations in Results

The significance of two factors on findings was measurable. Petragnani's medium was employed when the culture procedure was first initiated. In 1949, however, tests were conducted in the Board of Health Laboratories to assess the relative sensitivity of available mediums. It was found by us, as it later was found by other laboratories, that Lowenstein's medium was somewhat superior. In our hands the yield in positives was approximately 20 per cent higher on this medium as compared with Petragnani's. Since 1949 we have used this more sensitive medium. At first, one culture per specimen was inoculated. When it became practicable, two cultures per specimen were tried. During a ten month test period in 1951 the second culture per specimen provided a highly significant increase in the number found positive by culture. This duplicate culture obviously was needed and has been used since that time. Other factors, not subject to exact measurement, influenced the reliability of the procedure. There was, for example, a substantial variation in results depending upon the precise technic used in inoculation of the culture medium. The nature of equipment available for the preparation of mediums can, and has, modified results. Always there is the human element, and the experience and technical skill of the workers and the nature of the senior supervision provided are of much importance.

Future Outlook

Culture procedures in tuberculosis have been improved in the past, but what of the future? On the basis of reported findings and our own experience, we think Lowenstein's medium is as good as any presently available which is suitable for volume work in tuberculosis. There is need, however, for secure evidence. At least four other mediums warrant comparative evaluation. Recent recommendations have brought to the fore a human blood medium which must be considered. The opinion has been offered that two cultures using different mediums may be better than two simultaneous cultures using the same medium. It should be known also whether cultures in triplicate rather than in duplicate on each specimen are indicated. We need to know from experience in Florida which procedures provide the best possible results for us. Limitations in space and equipment made it impossible heretofore to consider comparative studies, but these obstacles have been removed by the new laboratory facilities in Jacksonville. Now we must expand the capacity of our laboratory staffs to provide needed time for these technical evaluations of high practical significance.

The best of presently available procedures must be selected and used. Still, one cannot escape the belief that present bacteriologic technics are not adequate to meet present needs. Experience in other fields of microbiology provides at least a hope that there may be a comparable development in the field of tuberculosis. For the detection of *Salmonella*, there are now available

highly selective liquid enrichment mediums. The specimen for culture is first inoculated into an enrichment broth; after incubation the growth is transferred to the plating mediums. On many occasions in comparative observations we have found as many as 10 per cent of specimens positive for *Salmonella* by using this enrichment medium, while none at all or at most less than 1 per cent were positive on using similar culture procedures but without the enrichment. There will be, in the years ahead, an increasing need for a comparable enrichment technic which will permit the identification of *M. tuberculosis* when the organisms are present in specimens in only small numbers.

A new bacteriologic technic has been devised for isolating organisms which are present in only small numbers, as for example, the detection of *Salmonella typhosa* in water. The material to be cultured is passed through a special membrane filter, and the filter pad serves as the inoculum. It appears to have particular promise in the examination of such specimens as urine, spinal fluid, or pleural fluids. Possibly it can be adapted for wider usage. The early reported results warrant wider trials of the procedure in tuberculosis.

Because of difficulties in the collection of specimens, it may be assumed that gastric washings will be submitted for examination only in exceptional cases. It is noteworthy, however, that in the past two years of 918 specimens of gastric washings tested in the Board of Health's Jacksonville and West Palm Beach Laboratories, 120 (13.1 per cent) were positive for *M. tuberculosis;* a higher percentage of positive findings than in the sputum specimens submitted.

One problem beyond the control of the laboratory, which is of particular importance to public health laboratories, deserves mention here. Throughout the years it has been evident that findings by culture were relatively better in winter than in summer. There is no reason to expect more positives in specimens submitted in the winter than in those submitted in the summer, and findings by smear have failed to reveal any consistent difference in the proportion of positives according to season. During 1954, however, in the Jacksonville Laboratory, 12 per cent of the specimens received during the five colder months were positive by culture as compared with 6 per cent during the three hot summer months. It may be computed by applying the higher rate of positive findings for the winter months to the total specimens received throughout the year that 3,259 positive specimens were collected and submitted. When these specimens reached the laboratory, however, *M. tuberculosis* could be identified in only 2,732 specimens, an estimated loss, presumably through deterioration of specimens in transit, of 527 positive findings. The summer of 1954 was exceptionally hot, but in some degree this is a problem every year. Moreover, with less heavily positive specimens, which are to be expected in the future, the relative loss in positives will become more pronounced. It is urgent that there be strong emphasis on the importance, particularly during the hot seasons, of transporting specimens to the laboratory without delay. Prepared samples should be kept in the refrigerator until mailed, and time en route should be limited if possible to an overnight service. Furthermore, it is important, particularly in the South, to seek for some preserving medium or reagent which will permit the transportation of *M. tuberculosis* to the laboratory in a viable state during all seasons of the year.

Therapeutic Role of Antibiotics

The therapeutic use of antibiotics has given a new importance to laboratory work in tuberculosis, but it has added new problems. One, however, which was anticipated, has not been observed. We expected to find, with the more general use of antibiotics, an increasing number of specimens negative by culture but positive microscopically. We fail to detect evidence of such dead, dying or modified organisms in any significant number of the specimens of sputum submitted.

The declining sensitivity of many organisms to sulfonamides and antibiotics has been observed and recorded. Comparable data must be accumulated which will clearly reveal any change in sensitivity of *M. tuberculosis* to the newer therapeutic agents. Thus, the in vitro testing of sensitivity has a broad importance as well as a significance to the individual patient. Concerning the latter, it appears probable that in future clinical records the detailed bacteriologic findings defining the initial and the changing antibiotic sensitivity of *M. tuberculosis* in the particular case will be of high importance.

Three methods have been applied in sensitivity testing, namely, the direct, the indirect and the disk procedures. With the first, the initial specimen is inoculated directly to a series of cul-

ture mediums containing varying concentrations of the antibiotic. When large numbers of organisms are present, there is sufficient growth to provide a reliable indication of antibiotic sensitivity. Present specimens are not often suitable for the direct procedure since organisms are being found in relatively small numbers in an increasing proportion of the positive cases. In the indirect procedure, the organisms are isolated by culture, and the sensitivity test is performed by transferring a representative sample of the initial growth to a series of tubes with varying concentrations of the antibiotics being tested. This technic can be applied on specimens from which few organisms are isolated. The disk procedure is a modified indirect method in which a medium without antibiotics is inoculated, and disks with varying concentrations of antibiotics are applied to the surface of the medium. The antibiotic diffuses into the medium, and if the organisms are sensitive, there is a zone of no growth surrounding the disk. This method is widely used for rapidly growing organisms and currently it is being tried in tuberculosis.

The time now required for a sensitivity test by the indirect or the disk method is twice that required for the growth of *M. tuberculosis* in culture, in all rarely less than six weeks and occasionally as much as three months. Rapid sensitivity tests that there be an acceptance of uniorganisms which cause acute infections. Tests which previously could be read only after 18 or more hours of incubation can now be reported in about three to five hours. An indicator medium is used so that the earliest growth produces color changes in the medium and areas of no growth surrounding antibiotic disks are strikingly apparent zones. We hope it may be possible to modify this rapid test for use in tuberculosis.

It is of practical importance in antibiotic sensitivity tests that there be an acceptance of uniform concentrations for the performance of these tests. We have collected information as to the practice and recommendations of leading national laboratories working in the field of tuberculosis, including the Veteran's Administration, the United States Public Health Service, the Trudeau Laboratories and certain State Public Health Laboratories. On the basis of current usage in these laboratories, it would be concluded that the important test concentrations for streptomycin are 10 and 100 micrograms per milliliter, for para-aminosalicylic acid (PAS) likewise 10 and 100 micrograms per milliliter, and for isonicotinic acid hydrazide (INAH) 1 and 5 micrograms per milliliter. This consolidated opinion is therefore offered with the suggestion that, in the interest of uniformity, these levels be currently accepted as the ones to be used for antibiotic sensitivity testing in all laboratories in Florida.

Virulence Test

An examination to determine the virulence of isolated acid-fast organisms may be of high importance since saprophytes morphologically indistinguishable from *M. tuberculosis* are encountered occasionally. Up to the present, tests for virulence have required animal inoculation. There is, however, considerable interest in possible in vitro procedures. In our own laboratory, we have had wide experience with the in vitro testing of virulence of *Corynebacterium diphtheriae*. This procedure is based upon an immunologic reaction; the exotoxin of virulent organisms is precipitated by the antitoxin contained in the special medium used. In tuberculosis, the test is based on a chemical reaction. In 1948, Dubos and Middlebrook[2] recognized that virulent strains of *M. tuberculosis* would take up neutral red dye in an alkaline buffer solution while avirulent strains failed to do so. This cytochemical procedure has been evaluated by Richmond and Cummings[3] and by Hughes, Moss, Hood and Henson.[1] Up to the present time there has been agreement in the classifications of organisms by this in vitro test and by findings on animal inoculation. Only a small number of the "border line" acid-fast organisms, however, have been studied comparatively, and opinions as to the value of this procedure must be reserved. The test has the advantages of simplicity, low cost and availability of the results within a few hours. A virulence test in tuberculosis has practical clinical significance. Should findings suggest that any "acid-fast organism morphologically characteristic of tubercle bacilli" may be a saprophyte, then a virulence test should be requested. We retain "positive" cultures for this purpose for at least one month after the submission of the positive findings.

Other Problems

Attention is invited also to the problem of securing a reliable application of dependable laboratory procedures. Voluntary "check-testing" programs have proved of high value in improving the reliability of testing procedures in other fields.

When this program was first used in syphilis serology, a disturbing divergence in findings was discovered. Now as a result of "check-testing" combined with consultative assistance and educational activities, the findings by serologic tests in different laboratories, public and private, are closely comparable and of high reliability. Some similar attention to bacteriologic tests in tuberculosis is needed.

The most favorable location for studies designed to improve still further diagnostic bacteriologic procedures in tuberculosis is in those hospital and public health laboratories where this work is being done. There is, however, a serious obstacle. The staff ordinarily provided is the minimum designed to handle the daily load of diagnostic service. We in Florida have a responsibility to make our fair share of contributions to the advancement of knowledge. This cannot be done by using spare moments; it requires a generous amount of time of highly competent workers. There are problems in the bacteriologic diagnosis of tuberculosis, and a most important one is the more adequate staffing of our laboratories.

Finally may I, with you, join in tribute to those who are doing highly important laboratory work in tuberculosis which involves daily exposure to substantial amounts of infectious material? Far too few are willing to undertake this work, but we have in Florida a nucleus of highly competent bacteriologists with particular interest in this field. We shall advance more rapidly when these persons of ability can devote a greater portion of their time to work in tuberculosis.

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Box 210.

ABSTRACTS

Benign Tumors of the Gastrointestinal Tract. By Martin G. Gould, M.D. South. M. J. 48:623-626 (June) 1955.

Although benign tumors of the gastrointestinal tract involving the esophagus, stomach, duodenum, jejunum, ileum and colon are comparatively rare, they are by no means insignificant lesions, and their preoperative diagnosis is often difficult to make. This author believes they occur more frequently than suspected. Although the majority are probably asymptomatic throughout life, he observes, a sufficient proportion will give rise to serious, even fatal, hemorrhage, cause obstruction, or undergo malignant change. In most of these instances there are no specific symptoms. In view of these facts he recommends that the patient having repeated gastrointestinal hemorrhage, with the cause remaining undiagnosed, be subjected to an exploratory operation. In his opinion all benign tumors should be removed because of their malignant potential. Illustrative cases are presented demonstrating benign tumors of the esophagus, stomach, duodenum, small intestine and colon.

The Role of Cytodiagnosis in Preclinical Cancer of the Prostate. By Samuel A. Gunn, M.D., and J. Ernest Ayre, M.D. J. A. M. A. 158:548-551 (June 18) 1955.

Preclinical cancer of the prostate is defined in this paper as characterized by the morphological features of malignancy existing in the prostate, while the disease is not yet recognizable as such by the examining finger. In previous studies, using cytology as an investigative tool, these authors obtained results indicating that preclinical cancer of the prostate is a recognizable entity when this valuable technic is effectively applied. In the present article they discuss this technic and present 8 illustrative cases. They report screening cytologically by this simple office procedure 618 patients clinically normal for cancer of the prostate. Unsuspected positive cytodiagnosis for malignancy was found in 37 cases, leading to further clinical investigation and evaluation. This latest study leads them to conclude anew that cytology, properly applied, can aid in the detection of cancer of the prostate in a preclinical stage.

Submucous Thrush: Chronic Moniliasis of the Buccal Mucous Membrane. By Morris Waisman, M.D. South M. J. 48:694-700 (July) 1955.

Discussion of the chronic, infrequently observed form of deep infection by Candida albicans known as submucous thrush is based upon a series of 8 cases in otherwise healthy patients subjected to clinical and histopathologic examination. Mechanical abnormalities which predispose to the development of perlèche are pointed out. It is postulated that when there is laxity with folding of tissues at the corners of the mouth, the adjacent mucous membrane of the cheeks necessarily participates in the same process.

Injured continually by the teeth, the tissue may become vulnerable to invasion by C. albicans already proliferating in adjoining lesions of perlèche. There was no evidence in the author's material that nutritional deficiency or vitamin deprivation was responsible, directly or indirectly, for the development of monilial infection of the lips and mouth.

Treatment may be carried out successfully by fulguration of the buccal lesions, and by competent prosthodontic correction of the "bite" and restoration of the proper contour of the mouth.

Prolapse of the Vaginal Vault Following Hysterectomy. By Harold H. Ring, M.D. South. M. J. 48:679-681 (July) 1955.

The seemingly uncommon complication of prolapse of the vaginal vault following hysterectomy may well occur more frequently now that this operation has become a relatively common procedure. The cause of the prolapse remains unknown, but it is suggested that the state of nutrition may be a factor since the condition usually is observed in the obese or underweight patient. In the 6 cases reported here all of the patients except 1 were overweight and all were elderly, the average age being 65 years. The duration of the prolapse was not known definitely, but in all cases it occurred after other changes of advancing age were manifest, and in some cases many years had elapsed since the hysterectomy.

A relatively simple vaginal operation is presented which can be employed successfully to correct prolapse of the vaginal vault following hysterectomy, in women who no longer require a functioning vaginal tract. It also can be used at the time of vaginal hysterectomy to prevent the occurrence of this complication in the future.

Diffuse External Otitis: A New Classification and Guide for Treatment. By Curtis D. Benton, Jr., M. D. South. M. J. 48:546-550 (May) 1955.

In a study of otitis externa reported here, the clinical findings provide a classification which lays a practical basis for successful treatment. This new system classifies cases of diffuse external otitis into four types on the basis of the appearance of the external auditory canal. Each type has a remarkably consistent bacterial flora so that the otologist can predict the results of a culture study in every case with an 80 to 100 per cent accuracy.

The characteristics and bacterial flora of the four types are described as: type 1, some degree of diffuse swelling; gram negative bacteria, 90 per cent; type 2, no swelling, crumbly whitish debris; gram positive bacteria, 80 per cent; type 3, no swelling, discharge; gram positive bacteria, 90 per cent; type 4, grey or black mass, like wet newspaper, against the drum; fungi, 80 per cent. The recommended treatment consists of proper cleansing of the canal, administration on a cotton tampon of a drug proved to inhibit the predominant organism, and dusting of the ear canal with an antibacterial and antifungal powder, this final step being of vital importance as the condition is not cured until the ear canal is observed to have remained dry for two days after being coated with powder. The medicaments of the author's choice are: type 1, Aerosporin Otic two parts and Cresatin one part; types 2 and 3, Furacin ear solution and Cresatin ear solution, equal parts mixed; and type 4, Cresatin.

The results of treatment in 300 cases showed cure in 90 per cent within six days and in 95 per cent within 14 days. Subsequent infections were observed in 30 cases, or 10 per cent. The characteristics in a small group of difficult cases representing 3 per cent also are discussed.

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William M. Rowlett, M.D., 1933.....*Tampa*
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Walter C. Jones, M.D., 1941.....*Miami*
Eugene G. Peek Sr., M.D., 1943.....*Ocala*
Shaler Richardson, M.D., 1946.....*Jacksonville*
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Joseph S. Stewart, M.D., 1948.....*Miami*
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Association's Annual Convention Miami Beach, May 14-16

The Eighty-Second Annual Meeting of the Florida Medical Association is to be held a month later than usual this year. It is scheduled for "the merriest month in all the year . . . the merry month of May," opening on Monday, the fourteenth, and continuing through Wednesday noon, the sixteenth. The meetings of the large number of specialty groups will be held on the two days immediately preceding.

For the first time in the Association's long history, the annual convention will take place in Miami Beach. Miami was the convention host in 1913, 1919, 1938 and 1947, and Hollywood in 1933, 1942, and 1950 to 1954 inclusive. This year Miami Beach is the favored city with the fabulous Hotel Fontainebleau serving as headquarters. This delightful spot on the beach with the blue Atlantic on one side and the attractions of Miami Beach and the entire Miami area on the other side should be ideal in mid-May. That is the period between the winter and summer tourist seasons, there is no conflict with the Easter season, and there are few conflicts with other medical meetings. Both the time and the place of the meeting should contribute greatly to a record attendance.

The scientific program measures up to the usual excellent standard. Among the 18 essayists are three distinguished guest speakers: Dr. Shields Warren, of Boston, Professor of Pathology at the Harvard Medical School and President of the American Board of Pathology; Dr. James J. Callahan, of Chicago, Professor of Bone and Joint Surgery at Stritch School of Medicine, Loyola University; and Dr. Lauren H. Smith, of Philadelphia, Professor of Psychiatry and Neurology at the University of Pennsylvania School of Medicine and Physician-in-Chief and Administrator of The Institute, Department of Nervous and Mental Diseases, Pennsylvania Hospital. "The First Decade of Atomic Medicine" is the subject of the address by Dr. Warren, who studied firsthand the effects of atomic radiation on Japanese victims and has directed much of the research work on the biologic effects of this form of energy. Dr. Callahan's subject is "Intertrochanteric Fractures and Fractures of the Neck of the Femur." Dr. Smith will speak on "A New Era of Therapy in Psychiatry."

The President's guest speaker will be Dr. John W. Cline, of San Francisco, past president of the American Medical Association. His subject is "Biliary Tract Surgery." Dr. Elmer Hess, of Erie, Pa., President, and Dr. Dwight H. Murray, of Napa, Calif., President-Elect of the American Medical Association are both expected to be present and address the Association.

The commercial exhibits will be displayed in the Grand Ball Room. All space has long since been assigned. The scientific exhibits will be given prominent display in the adjoining spacious foyer, and there will be others in the television area.

Formerly, the March Journal was the convention number, but this year, with the meeting coming in mid-May, the April Journal will carry the detailed information and the program in full. The Association members are urged to keep in mind that the convention "falls upon a day in the merry month of May" when they will be expected to be on hand to make merry and to profit by the highest type of professional stimulus.

The President's Health Message

As this issue of The Journal goes to press, President Eisenhower's special message on health has just been received by the Congress. It differs in several important respects from programs proposed by the President during the last two years on which the Congress failed to act.

Conspicuously absent, temporarily at least, was the controversial program for federal reinsurance of voluntary private prepayment insurance plans for hospitalization and surgical insurance, which the American Medical Association opposed. The administration, the President said, is now considering whether federal laws may be changed to permit private organizations writing health prepayment insurance to share or pool their risks "to offer broader benefits and expanded coverage on reasonable terms in fields of special need." There are indications, he observed, that this method might make for more rapid progress. He added, however, that he would renew his proposal for federal reinsurance "if practical and useful methods" cannot be developed along the alternative line.

New this year was the President's request that the Congress authorize a $250,000,000 five year federal program to expand construction of medical research and teaching facilities. President Eisenhower proposed that the federal government assume a more active partnership "in the unending struggle against disease and disability." "In the light of the human and economic toll still taken by disease, in the light of the great opportunities open before us," he declared, "the nation still has not summoned the resources it properly and usefully could summon to the cause of better health."

The funds proposed in this five year federal program for expansion of medical research and teaching facilities would be available to schools of medicine, osteopathy, public health, dentistry and other research institutions. The President specified, however, that such institutions would be required to supply "at least equal amounts in matching funds."

The presidential message also proposed a 28 per cent increase in federal medical research expenditures already proposed in the budget message. The total of $126,525,000 asked for research by the National Institutes of Health includes $32,437,000 for cancer, $22,106,000 for heart disease, $21,749,000 for mental illness, $12,196,000 for neurology and blindness, $9,799,000 for infectious and parasitic diseases, $2,971,000 for dental disorders, and $11,922,000 for general research.

Warning again that the rate at which physicians are being trained is barely keeping pace with population increases, he mentioned serious shortages already in specialized fields such as psychiatry, pediatrics, physical medicine and rehabilitation. He pointed out that the increase in funds he has requested for the National Institutes of Health and the National Science Foundation will permit a major increase in trainees and research fellows. Also, the proposed program of construction grants for medical research and teaching facilities will permit medical, dental and other professional schools to expand their student capacity and provide for the training of more physicians, scientists, dentists and other health workers.

As additional federal aid in meeting the problem of existing personnel shortages in the health field, he renewed the proposals in his health message of last year for a five year program of grants for training practical nurses, traineeships for graduate nurses, and authority to establish traineeships in other public health specialties.

Taken as a whole, the President declared, his program is aimed at "a proper distribution of re-

sponsibility among the many groups which make up the health services of the nation — health professions, educational institutions, foundations, industry and all levels of government." In conclusion, he expressed his desire to adhere to fundamental American concepts in these words:

"The role of the federal government in this great effort is that of a partner. The federal government should support the efforts of the states and communities and private agencies. It should encourage the individual initiative and industry inherent in our free society. The specific measures which I have placed before you are conceived in terms of these basic American principles; they provide promise for a renewed and reinvigorated attack on our health problems."

The medical profession will welcome the reversal of the stand on federal reinsurance and all efforts to reverse the trend toward socialization which the present administration found gaining disturbing headway in the nation's legislative halls.

Legislative Program Now in the Making

In the over-all legislative program of the Association it is the policy to shape up proposed legislation a year in advance of the meeting of the state legislature. Now is the time to begin for the legislature meets again in April 1957.

It is highly important that the Association's component county medical societies submit their legislative proposals now to the Committee on Legislation and Public Policy for study and inclusion, if feasible, in the program to be sponsored in the 1957 legislature. Letters have gone out to the president, secretary and legislation committee members of each county medical society urging immediate consideration of the matter.

The societies are advised that if they anticipate requesting legislative action at the forthcoming session of the legislature and desire the assistance of the Association's Committee on Legislation and Public Policy, they should prepare their bill carefully and send a typed copy to the office of the Association, Box 1018, Jacksonville, by March 31, 1956. That date marks the end of the present month.

The Committee will review all bills received in this way. It will then present recommendations for a definite legislative program at the Pre-Legislative Joint Meeting of the Board of Governors, members of the House of Delegates, Bureau of Public Relations and Committee on Legislation and Public Policy. This meeting will take place in May immediately preceding the annual meeting of the Association. So make haste to prepare and send in all legislative proposals.

College of Surgeons Meeting Held in Jacksonville

Outstanding surgeons from many parts of the nation came to Florida in mid-January to address surgeons from Southern states who attended the first 1956 sectional meeting of the American College of Surgeons, held in Jacksonville, January 16, 17 and 18. There were 437 doctors in attendance, some 150 of them accompanied by their wives, for whom special entertainment was provided.

At the opening session, interest was centered on a symposium on the management of mass casualties. The various aspects of this subject coming under discussion were the nature of atomic weapons, civilian and hospital organization, and surgical management of mass casualties. Local alertness and repeated practice sessions were urged in the interest of preparedness in case American cities suffer a disaster, whether atomic or otherwise. Specific methods of organizing hospitals were recommended. While emphasis was placed on the handling and treatment of war-caused casualties, the theories and suggestions advanced would be applicable to mass injuries resulting from floods, fires, hurricanes or any major disaster.

Presiding at the banquet on Monday night was Dr. I. S. Ravdin, Professor of Surgery at the University of Pennsylvania School of Medicine and Chairman of the Board of Regents of the American College of Surgeons. The featured speaker was Dr. Paul R. Hawley, of Chicago, The Director of the American College of Surgeons. A motion picture entitled "Danger at the Source" concluded the program for the dinner meeting. Sponsored by the National Fund for Medical Education, this picture emphasized the needs of medical education in relation to the nation's health requirements and to the preservation of academic freedom and equality of educational opportunity.

Of particular interest was a presentation by Dr. Charles D. Sherman of the University of Rochester School of Medicine entitled "Esophageal Reconstruction by Colon Transplant," in which he outlined in a motion picture a method of reconstruction of the esophagus. During the past three years, a group of surgeons at the University of Rochester School of Medicine has been engaged in reviving and perfecting an old method of using a segment of colon, placed retrosternally, to bridge the gap between the cervical esophagus and the stomach. They have used this operation successfully in several types of patients. It is indicated in certain adults with cancer of the esophagus, in some infants born with atresia or tracheoesophageal fistulas, and in those patients whose esophagus is damaged by ingestion of corrosive materials.

A symposium on Cancer and one on Trauma were other features of the well planned practical program. In addition, there were panel discussions on Biliary Tract Surgery, on Varicose Veins and Leg Ulcers, and on Intestinal Obstruction. Excellent medical motion pictures were shown at various times throughout the three day meeting. The concluding presentation was a Cine Clinic symposium.

Among the many excellent papers presented was one by Dr. Samuel McLanahan of the Johns Hopkins University School of Medicine on "Diverticulitis of the Colon." He predicted that diverticulosis would be encountered more frequently by surgeons in the future since today the complications of diverticulosis, both inflammatory and hemorrhagic, are lending themselves more and more favorably to modern concepts of surgical treatment. "Among these complications," he observed, "are the relatively rare 'free' perforations with resulting peritonitis—truly surgical emergencies; hemorrhage which occurs more often than we used to believe and which can be exsanguinating; acute 'hot' diverticulitis, usually responding to conservative measures, but sometimes requiring prompt surgery — and sometimes encountered very unexpectedly; abscess and fistula which may become very complex, often demanding stage operations; chronic diverticulitis characterized by pain, obstruction and bleeding, a form of the disease in which surgery today has a great deal to offer; and finally the difficult problem of the differentiation between diverticulitis and carcinoma, and the fact of their coexistence in many instances, surgery being increasingly indicated to settle this dilemma and to relieve these patients."

The local Advisory Committee on Arrangements consisted of Drs. Kenneth A. Morris, Chairman, Donald M. Baldwin, Frederick H. Bowen, John R. Browning, Samuel M. Day, Karl B. Hanson, Edward Jelks, F. Gordon King, Raymond H. King, Wilbur C. Sumner, Frederick J. Waas and Ashbel C. Williams. On the Florida Counseling Committee were Dr. Morris, Jacksonville, Chairman; Perry D. Melvin, Miami, Secretary; and Drs. Duncan T. McEwan, Orlando, David R. Murphey Jr., Tampa; and Donald W. Smith, Miami, Counselors.

Outstanding Graduate Course Draws Large Attendance

The Tenth Annual University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology was held in Miami Beach the week of January 16. As in recent years, the Sans Souci Hotel was headquarters. Registrants for this 1956 meeting numbered 300. They came from 39 states and there were 10 from Canada.

This important feature of Florida's program of postgraduate medical education has throughout the decade of its existence attracted nationwide attention and grows more popular year by year. The first three days of the week are devoted each year to Ophthalmology and the last three to Otolaryngology.

The lectures on Ophthalmology were delivered this year by Dr. Harold G. Scheie, of Philadelphia, substituting for Dr. Francis Head Adler, also of Philadelphia, who was ill; Dr. Arthur Gerard DeVoe, of New York; Dr. Michael J. Hogan, of San Francisco; Dr. A. D. Ruedemann, of Detroit; and Dr. C. Wilbur Rucker, of Rochester, Minn. The lecturers on Otolaryngology were Dr. Frederick A. Figi, of Rochester, Minn.; Dr. Charles E. Kinney, of Cleveland; Dr. John R. Lindsay, of Chicago; Dr. Bernard J. McMahon, of St. Louis; and Dr. Lewis F. Morrison, of San Francisco.

The usual midweek social features attracted a large attendance. Many guests attended the informal gathering at the cocktail hour. More than 300 were present at the annual dinner which followed at the Saxony Hotel.

Midwinter Meeting of Florida Society of Ophthalmology and Otolaryngology

The Florida Society of Ophthalmology and Otolaryngology held its ninth midwinter convention on Jan. 18, 1956, at the Sans Souci Hotel in Miami Beach. President Charles W. Boyd presided. As in previous years, the meeting was held in conjunction with the Midwinter Seminar in Ophthalmology and Otolaryngology sponsored by the Department of Medicine of the Graduate School of the University of Florida.

Distinguished guest speakers presented the scientific program. Dr. Harold G. Scheie of Philadelphia spoke on "Tonography in the Clinical Management of Glaucoma," and the subject of the address presented by Dr. Frederick A. Figi of Rochester, Minn., was "Carcinoma of the Larynx."

The many guests present made the attendance unusually large. At the conclusion of the meeting, the members and guests and their wives enjoyed an informal gathering in the Blue Sails Room. The annual dinner followed at the nearby Saxony Hotel.

Graduate Medical Education Annual Short Course

The Twenty-Fourth Annual Graduate Short Course for doctors of medicine will be held at the George Washington Hotel in Jacksonville, June 25-29, 1956. As in former years, this course will be presented again this year by the Department of Medicine of the Graduate School of the University of Florida in cooperation with the Florida Medical Association and the Florida State Board of Health. The Committee on Medical Postgraduate Course met Nov. 20, 1955, at which time the general policies were established, the place of presentation designated and the general plans approved. As in previous years the first three days of the course will be devoted to Pediatrics and General Medicine and the last two days to Surgery and Gynecology. This year Psychiatry will be presented the first three days also. In addition there will be an evening meeting dealing with the commoner disorders of the eye under the sponsorship of the Florida Council for the Blind. Further details will be announced later.

The policy of planning this course primarily for the general practitioner will be adhered to as in the past. The complete program will be published in a later issue of The Journal.

Gastroenterology Course

The graduate course preceding the Short Course this year will be on Gastroenterology and will be presented Thursday, Friday and Saturday, June 21-23. Although the course is limited to the field of gastroenterology, it will be of interest to all practicing physicians.

Medical Education Week April 22-28

A major public relations project for 1956 is the first observance of National Medical Education Week, April 22-28. For the past several months the four sponsoring organizations — the American Medical Association, the Association of American Medical Colleges, the National Fund for Medical Education, and the American Medical Education Foundation — have been at work with the various mediums of public information to promote this observance. This program is being developed to highlight progress in medical education and eliminate many popular misunderstandings regarding the supply of physicians, the number of medical school graduates, and the alleged control of the profession over the number of students graduated.

A wide variety of suggestions and aids for radio and television, newspapers, magazines, and community organizations has been sent out to some 700 state and community chairmen selected by local medical societies. In each case, the chairman doubtless has already or will soon be calling on his colleagues and also representatives of the Woman's Auxiliary, medical schools, hospitals, and all associated groups in the area to serve on committees handling local observances.

From the progress made so far there is every indication that a great segment of the American people will, during this special week next month, hear of and appreciate the strides and accomplishments that have been made by the nation's approved medical schools. Now that Florida, so long without a medical school, can boast of two within its borders, members of the Association will take particular pride in promoting this first Medical Education Week and participating fully in its activities.

Heart Association Television Educational Programs

A series of educational programs pertaining to the heart has been regularly scheduled throughout the winter and spring months on WMBR and WJHP television stations in Jacksonville. Now in progress, this series is sponsored by the Duval District Heart Association, which operates as a chapter of the Florida Heart Association, an affiliate of the American Heart Association.

The program has aroused wide public interest and is the first prolonged seasonal program to be presented in the state. It began in November 1955 and so far is scheduled through April of this year. The first subject was "Patent Ductus," and other subjects presented have been "The Heart Association," "Rheumatic Fever," "Heart Attacks," "Heart Murmurs," "Heart Catheterization," "Strokes," and "Diet and Heart Disease."

Jacksonville physicians participating in these programs up to this time have been Drs. Roy M. Baker, C. Burling Roesch, Nathaniel Jones, Hugh A. Carithers, Lawrence E. Geeslin, Karl B. Hanson, J. K. David Jr., Mason Romaine III, Ivan Isaacs, Simon D. Doff, C. Ashley Bird, James L. Borland and Joseph J. Lowenthal. The program on "The Heart Association" was presented by Mr. Richard P. Daniel, President, Mrs. Waldo Norris, a member of the Board of Directors, and Mrs. Mamie S. Patrick, Executive Secretary.

Comprising the Duval District Heart Association are nine counties: Baker, Bradford, Clay, Columbia, Duval, Hamilton, Nassau, St. Johns and Union. The headquarters is at 425 West Duval Street in Jacksonville. The basic program of the organization is research, education and community service.

BIRTHS AND DEATHS

Births

Dr. and Mrs. John G. Lane Jr., of Jacksonville, announce the birth of a son on January 12, 1956.

Dr. and Mrs. William M. Leavenworth, of Jacksonville, announce the birth of a daughter, Margaret Isabel, on January 5, 1956.

Dr. and Mrs. Frank G. Long, of Jacksonville, announce the birth of a daughter, Mary Eileen, on January 8, 1956.

Deaths — Other Doctors

Lewis, Austin P., Miami	December 27, 1955
Lowrie, Thomas L. (Col.), Miami	December 30, 1955
Wilson, Herbert, Fort Myers	December 26, 1955
Cammack, K. R., Grove Hill, Ala.	January 14, 1956

OTHERS ARE SAYING

The Small Arts of Being a Physician

Be clean and neat both in person and in clothing. Always be clean-shaven, always have clean nails, always wear clean linen, never need a haircut. Always have your shoes shined, and never wear shoes run-down at the heel. See that your clothes go regularly to the cleaner. And see that your clothes are in good taste. Good taste permits a wide variation in choice as to cut and color. If you like color, wear it, but be sure you know how to pick colors that do not scream at each other. If there is any doubt in your mind, stick to solid colors. One of the best-dressed doctors I ever knew was never seen in anything but gray flannel suits, white shirt, and solid color necktie. There was a time when it was possible to go into the average small town and have an excellent chance to identify the local doctor by his appearance alone. That day is past — but there is no reason why any physician's appearance should cause him to be mistaken for anything but a gentleman.

That word gentleman implies other things as well. Do not smoke in the presence of a lady — even in your own office — without her permission. Never smoke — nor permit a patient to smoke in your examining room. Do not smoke in a patient's room either in his home or in the hospital without asking permission and preferably not then. Do not chew gum except in the privacy of your room. Public cud chewing is for cows. Do not see a patient in your office, in his home, or in the hospital with the odor of alcohol on your breath. The day of old Doc Thingummy "who really wasn't any good until after a few drinks" is no more. Your patients are intelligent enough to know that your judgment is not as good after even one drink as it was before. Don't let them think that you are offering them anything but your best — manners included. I have spoken of smoking and drinking. I shall touch only lightly on eating. First, food should never be worn. Last, I question the impression on a patient of a physician's advice as to reducing as a help in hypertension, arthritis, and the like if the physician is too markedly overweight himself. To maintain a good figure requires only one thing — self-discipline. Anyone too lazy or too complacent to discipline himself must be a poor advocate indeed of self-discipline for his patients.

Let us now go to your surroundings. There is nothing unethical, illegal, or decadent about having both comfort and beauty in your office. A dozen golden oak chairs will probably hold your patients — but a patient who has been sitting in a comfortable chair in a pleasing room, with a good engraving or picture or two on the wall will enter your consulting room in a better frame of mind than one who had squirmed around on a hard bench in a cheerless cell. It is also a very pleasant idea to subscribe to two or three really good magazines which may be deducted as a business expense and try to get through them at home and then have them in the waiting room by the time they are a week or so old. I would recommend the *National Geographic* very highly in this category since it appeals to all ages, and even to that occasional patient who can't read.

Remember that your patients are people. See them by appointment — office hours as such are relics of barbarism. An appointment system saves your patients time and contributes to your own dignity. It keeps your patient from sitting for thirty minutes between a woman with a crying uriniferous baby on her lap, and a man with a cough and coryza. Your wife wouldn't go to her hairdresser without an appointment — and surely a physician should be able to manage his business as well as a hairdresser.

You are going to spend many hours a day in your consulting room for the rest of your working life. There is no reason why it should not resemble the library or small sitting room of your own home.

When a patient enters your consulting room, stand up and greet him by name. If you know enough about him — and you should about most of your patients — make some personal reference to his way of life. How is his golf? Wasn't it nice his Susie got such a nice writeup for her part in the school play? That immediately makes him an individual in whom you are interested — not just another patient.

While he is in your consulting room give him your undivided attention. Do not fiddle with papers on your desk or look up a phone number or start getting out the sphygmomanometer and stethescope while he is retailing his symptoms. Listen — and listen as though every word he says is important.

Never lie to patients unless you are completely convinced it is for their greatest ultimate good. Learn to judge with whom it is best to be a little nonchalant about the severity of symptoms and when to be a bit of an alarmist, but guard yourself most carefully against a fixed attitude of being either always nonchalant or always an alarmist. Try never to hurry a patient and never refuse to discuss anything he wants to discuss. Also, be honest with him in discussing fees. If he wants to know what some illness is probably going to cost him, try and tell him — and if you know he is hard up, temper the wind to the shorn lamb — you can make it up on someone else next week. When he goes into your examining room, let him find that completely professional. Be as meticulous about the linen of your office as you are about your own. Have an examining table that has a paper covering and see to it that it is changed after each patient. Let each patient see you wash your hands after you have examined him. If instruments or appliances are in view see that they are polished and spotless. Make a point of putting each instrument you have used in the sterilizer so that the patient sees you do it. When he leaves, see him to the door as though he were a departing guest — and tell him that you hope he will feel much better in a day or two.

Now let us go into the patient's home. Leave your galoshes outside or in the vestibule — and don't drop your wet coat or hat on an upholstered chair in the hall. When you are greeted by the lady of the house, it will flatter her if you notice something about her home — she has new wallpaper or new paint — or a new piece of furniture and you admire her taste. When you get in the sick room, pull a chair up and sit beside the bed. Never sit on the bed. And put your bag on the floor — not on a chair or on the clean spread that was just put on the other twin bed in honor of your coming. Let me say again — do not smoke in a sick room — and go to the bathroom and wash your hands before you leave the house.

You may by this time be feeling that I am wasting your time with a host of trivia — that if a patient is ill he needs medical knowledge and you are prepared to give him that, but that if he wants his hand held and his ego flattered, he can just as well go to some Fancy Dan who hasn't your knowledge and has to rely on artifices. If any of you feel so, my heartfelt advice is to get into a specialty as soon as possible — one in which you do not have to see the same patient too many times. You who go into general practice will soon find that a large proportion of your pa-

tients are afflicted only with the fear of disease, the fear of some small, unexplained symptom. To these people your interest, your sympathy, your small talk, your reassurance are of paramount importance — and in dealing with them even well-considered and aptly used flattery may be as important as is an antibiotic in pneumonia.

All these things are of value, however, only insofar as you really feel them. Unless you like people, unless you have an overweaning curiosity to know all about your patient, his illnesses, his family problems, his financial problems — and a feeling of real pleasure in occasionally making his burden easier — physically, mentally, spiritually — your interest and flattery will be a mockery which will eventually find you out. When people become really ill, they develop an almost child-like quality of knowing whether you really like them and are truly interested in them. If you are not — then do not even essay a life as a specialist — get a job with some insurance company.

A final word and I will let you go. Never forget that you are the heir of an ancient and honorable tradition. Your profession sets you apart a little from most other men. When you assume the hood of your doctorate, it bestows upon you a dignity which you must not betray. There will be some of your patients who will become your intimate friends and with whom you will be on terms of complete familiarity. But let that be of your choosing. It is possible to bear yourself in such a manner that any patient whom you ask to call you by your first name will be complimented — and that only a brash few will attempt it without your invitation. And it is possible to do this without acquiring a reputation for being upstage or snobbish. Try, from the day you enter practice to cultivate such a bearing and demeaner. If enough of you do so, we may yet put medicine back among the honored professions. —*Eben T. Breed, M.D., Nassau County Medical Society, from How To Make New Members Active Members of a County Medical Society, Public and Professional Relations Bureau, 1954.*

New York State J. Med.
56:45-46 (Jan. 1) 1956



STATE BOARD OF HEALTH

Present Status of Water Fluoridation

The progress of water fluoridation, since controlled studies were begun 10 years ago, has been most encouraging. In 1945, only the cities of Newburgh, N. Y., Grand Rapids, Mich., and Kingston, Ontario, were adding fluorides to municipal water supplies to control dental decay.

On Jan. 1, 1956, the American Dental Association Council on Dental Health reported that fluoridation programs are now in operation in 1,117 communities in the United States, with a total population of over 22 million. One of the world's oldest cities, Cairo, Egypt, has announced plans to fluoridate its water. More than two million persons are served by the city's water system, which originates in the Nile River. Other countries, in addition to the United States, which have fluoridation programs in operation include Brazil, Canada, Chile, Colombia, Germany, Holland, Japan, New Zealand, Sweden, and Switzerland.

Many years of study and research have been devoted to this public health measure. The dental benefits of fluoridation have been thoroughly explored. Our present knowledge about the value of fluorides in drinking water in the control of dental decay is based on studies started in the United States in 1908. Natural waterborne fluorides are common in this country. According to figures recently released by the U. S. Public Health Service, "About 65 million people in 8,000 towns drink water containing some fluorides naturally. People in 1,600 towns drink naturally fluoridated water containing 0.7 parts of fluoride, or more, per million parts of water. The population of these towns is about 4,500,000." Although the recommended amount of fluorides is one part fluoride per million parts of water, some 400 towns for years have used water naturally containing 1.5 parts, or more.

Studies have been conducted among people who have lived continuously in these areas where the drinking water naturally contains high concentrations of fluoride. The research work done on both natural fluoride water and on artifically fluoridated water has been painstaking and thorough, yet no scientist has been able to find any harmful effects from fluorides in the amount recommended for the control of dental decay.

New impetus to the fluoridation program stems from the final 10 year report of the New-

(Continued on page 752)



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(Continued from page 749)

burgh-Kingston study. It was made in December 1955 before a meeting of dentists at the New York Academy of Medicine. It securely establishes both the efficacy and safety of this measure. These findings are in agreement with the other 10 year studies in Grand Rapids, Mich., and Brantford, Ontario. All show that controlled fluoridation reduces dental decay from 58 to 65 per cent and that it is not harmful in any way.

In the New York study, after extensive tests, including roentgenograms of bone formation, detailed blood analyses, and measurements of growth rates, "no difference of medical significance" could be found between the boys and girls of Newburgh where the water was artifically fluoridated and those in Kingston who served as a control group. Fluoridation had no effect on the children's growth, weight, height, blood composition, bone formation, urine, vision, or hearing. New York's state health officer, Herman E. Hilleboe, announced.

Despite some opposition, mostly by nonprofessional persons, Florida has made substantial progress since the first city, Gainesville, started fluoridation in 1949. Fourteen Florida cities, including Miami, are now using artifically fluoridated water. Five additional towns have approved it. Twenty communities in Florida, including Jacksonville and Sarasota, have natural fluorides in their water supplies in approximately the correct amount.

The cities in Florida which have adopted this measure are certainly far too few. There is much to be done. The people of our state must be well informed on this and other preventive health measures. It is clearly the duty of the dental and medical professions to continue to inform the public of the value of this preventive health procedure.

Water fluoridation deserves an especially high priority among the health programs in every community in Florida. The great reduction of tooth decay by water fluoridation can improve the dental health and the total health of our future citizens at a remarkably small cost, with safety, and with lasting benefits. Fluoridation, therefore, is recommended to all Florida communities.

The Florida State Dental Society and its component units and many physicians in Florida have been helpful in the progress made so far in the state. Continued support is needed. There are many towns and cities in Florida which could and should adopt fluoridation without delay.

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FOR SALE: Florida waterfront homesites on famous Saint John's river. Finest boating and fishing four miles from DeLand. Beautiful high lots from $2000. Terms with no interest. Literature. Rita Roepke, Eustis, Florida.

OPHTHALMOLOGIST - OTOLARYNGOLOGIST: Seeks Florida location. Age 36. University trained. Board eligible. Available July 1. Write Leland Glenn, M.D., 4157 Osborne Rd., N. Atlanta 19, Ga.

GENERAL SURGEON: Board eligible, 30 years old, married, two children. Training in all specialties, Florida license, desires association with individual or group leading to partnership, Group IV. Write 69-170, P.O. Box 1018, Jacksonville, Fla.

GYNECOLOGIST-OBSTETRICIAN: Wishes to live in Florida. American Boards (1955). Broad experience. Would like association with obstetrician or group. Write 69-171, P. O. Box 1018, Jacksonville, Fla.

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SITUATION WANTED: Assistant Professor of Surgery and Gynecology in Southern Medical School desires association with established Florida surgeon or group. Also capable of heading hospital teaching program. Board certified. University trained. Protestant. Age 35. Write 69-176, P.O. Box 1018, Jacksonville, Fla.

SITUATION WANTED: Allergist desiring practice in Florida. Fellow American Academy of Allergy, Fellow American Academy of Pediatrics. Age 35. Florida license. Write 69-174, P.O. Box 1018, Jacksonville, Fla.

ARE YOU LOOKING FOR MORE LEISURE TIME AND DIVIDED RESPONSIBILITIES? Diplomate, American Board of Internal Medicine; Fellow, American College of Physicians, and Fellow American College of Cardiology. Fifteen years successful private practice in Cardiology and Internal Medicine, wishes to team up with established man (or group) with similar qualifications, in south Florida, Miami Beach preferred. All replies will be held in strictest confidence. Write 69-175, P.O. Box 1018, Jacksonville, Fla.

RADIOLOGIST: University trained. Board certified. Full time midwestern medical school affiliation at present. Florida license. Age 31. Desires Florida location. Write 69-173, P.O. Box 1018, Jacksonville, Fla.

GENERAL SURGEON: Age 32, native Floridian, Florida license, completing training this June, Board eligible. Desires association with surgeon, group or clinic. Box 124, Cleveland Clinic, 2020 East 93rd Street, Cleveland 6, Ohio.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Allen, John J., Winter Park
Andrews, Frederick C., Mount Dora
Ayers, Sanford E., Winter Garden
Berry, James F., Fort Lauderdale
Collins, John P., Lakeland
Garber, Rudolph C., Jr., Sarasota
Garlington, William H., Ocoee
Green, David E., Haines City
Gregory, Laurence W., Sarasota
Hagan, Andrew D., Clearwater
Judd, Robert C., Pinellas Park
Katz, Harry M., Largo
King, Albert G., Jr., Lakeland
Lambert, Charles R., Fort Lauderdale
Lazzopina, Michael S., Hollywood
Lehman, David J., Jr., Hollywood
Menzies, Paul T., Pompano Beach
Miethke, John C., Rockledge
Montgomery, Wayne O., Lakeland
Moseley, Arthur, Jr., Winter Haven
Neefe, John R., St. Petersburg
Nickell, Leo C., Orlando
O'Malley, Joseph E., Orlando
Roberts, Charles M., Haines City
Rolfes, Harry F., St. Petersburg
Safian, Leroy S., Winter Park
Schmierer, Elmer J., Wildwood
Smith, Carl M., Clermont
Stutsman, Philip R., Wildwood
Valin, Jack L., Fort Lauderdale
Vidal, Fred L., Daytona Beach
Vomacka, Robert P., Clearwater
Walker, Robert T., Clearwater
Weaver, Thomas D., Clermont
Wright, Peter B., Orlando

Letters to our senators and representatives are invited frequently by the AMA Washington office. However, our Legislative Committee should study legislation so that our recommendations need not be parrot style. Although it would rarely disagree with the AMA opinion, a personal touch could be imparted in our letters.

—Picomeso Mail Bag, Pinellas C.M.S.

STATE NEWS ITEMS

Dr. Karl B. Hanson of Jacksonville was guest speaker at the joint meeting of B'nai B'rith in the city the middle of January. The title of his address was "The Middle Years."

Dr. Roger E. Phillips of Orlando has been appointed consultant in psychiatry at Anclote Manor in Tarpon Springs, a hospital for emotional readjustment.

The Mount Sinai Hospital of Greater Miami has announced its Sixth Annual Seminar. The date is May 17-20 in the Fontainebleau Hotel at Miami Beach. Dr. Harold Rand is chairman. His address is 4300 Alton Road, Miami Beach.

Dr. Benjamin J. Philips Jr. announces the opening of his office for the practice of obstetrics and gynecology at 2708 St. Johns Ave., Suite 10, Jacksonville.

Dr. Janet B. Sutton of Bartow was principal speaker at a January meeting of the Junior Woman's Club of that city. Her topic was "Fact and Fantasy About the Stork."

Dr. George W. Morse of Pensacola, retiring president of the Escambia County Medical Society, has been awarded a certificate of appreciation by the Society for his work last year. The presentation was made by Dr. Gretchen V. Squires, who succeeded Dr. Morse as president.

Dr. Clack D. Hopkins, head of the Communicable Disease Division of the Hillsborough County Health Department at Tampa, has retired from public health work after 24 years service.

Dr. Albert T. Fechtel of Jacksonville has been appointed assistant county medical examiner for Duval county. Dr. Fechtel replaces Dr. Samuel S. Lombardo who has resigned.

Dr. J. M. Ingram Jr. of Tampa was principal speaker at a January meeting of the Tampa Chapter, Daughters of the American Revolution. His topic was "Socialized Medicine."

Dr. Abraham R. Hollender reported on his recent trip to the Third World Assembly of the

Israel Medical Association at a gathering of greater Miami physicians the middle of January.

Dr. Albert G. Love IV of Gainesville has been elected a Fellow in the International College of Surgeons. The degree will be conferred upon Dr. Love at a meeting of the College in September, 1956.

Dr. Samuel J. Alford Jr. of Jacksonville has been named president of the Jacksonville Police Pistol and Rifle Club.

Drs. Dorothy D. Brame, Charles J. Collins, John P. Michaels and Robert L. Tolle of Orlando attended the meeting of the Florida Obstetric and Gynecologic Society held recently at Miami. Following the meeting in Miami, Drs. Brame, Collins, Thomas D. Cook of Orlando, and Jacob R. Rozier of Winter Park attended the meeting of the American Academy of Obstetrics and Gynecology in Chicago.

Dr. A. Judson Graves of Jacksonville has been elected a Fellow in the American College of Radiology.

Drs. Benjamin Glaser, J. Cornall Howarth and Carl S. McLemore of Orlando, and Dr. Henry J. Wiser of Winter Park have been made Fellows of the International College of Surgeons.

Drs. F. Gordon King, Joseph A. J. Farrington, Benjamin J. Philips Jr., Louie Limbaugh and Thomas H. Lipscomb, all of Jacksonville, served on the panel for a discussion of "A Common Sense Approach to Cancer" presented before the Woman's Club of South Jacksonville the middle of January.

Dr. Leander J. Graves of Tallahassee, Leon county health officer for 13 years before retiring about three years ago, has been presented a plaque recognizing his work as president of the Florida Public Health Association in 1941.

Dr. John M. Schultz of Miami has been elected a Fellow of the American Academy of Obstetrics and Gynecology.

Dr. Lawrence E. Geeslin of Jacksonville was guest speaker at a mid-January meeting of the Duval County Federation of Women's Clubs.

Dr. Joseph W. Pilkington of St. Petersburg has been elected a Fellow of the American Academy of Obstetrics and Gynecology.

Dr. Rothwell C. Polk of Jacksonville presented an address on "Cancer" at the San Marco Theatre in that city February 2 following the showing of a film on "Self-Examination of the Breast."

Dr. Mason Trupp of Tampa was principal speaker at a meeting of the parents' group, United Cerebral Palsy, held late in January in the cerebral palsy clinic building on Davis Islands.

Dr. Douglas G. Scott of Jacksonville Beach has been presented the Legion of Honor Award by the Kiwanis Club of that city in special recognition of his 25 years as a member of the Club. The presentation took place at a meeting of the Club early in February.

Dr. John A. Coleman of Plant City has been named Man of the Year by the Junior Chamber of Commerce there. Dr. Coleman was a member of the first graduating class from Plant City High School and played on the school's first football team. Some 42 years later he was active in the development of a new high school and stadium for the city.

Dr. Joseph Canipelli of Jacksonville discussed "The Influence of Religion on Medicine" at the January meeting of St. Paul's Guild in that city.

Dr. William H. Turnley of Ocala read a paper on "Hemicrania, or One-Sided Sphenopalatine Ethmoid Headache" before the American Laryngological, Rhinological and Otological Society at the annual meeting at Houston, Texas, January 27.

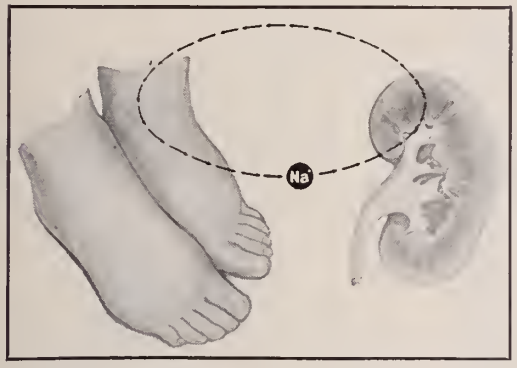
Dr. Edward Jelks of Jacksonville has been appointed a member of the Duval County Welfare Board by Governor LeRoy Collins. Dr. Jelks replaces Dr. Walker Stamps, who resigned recently.

Dr. Walter H. Bailey of St. Petersburg has been appointed a consultant in neurology and psychiatry at Anclote Manor at Tarpon Springs, a hospital for emotional readjustment.

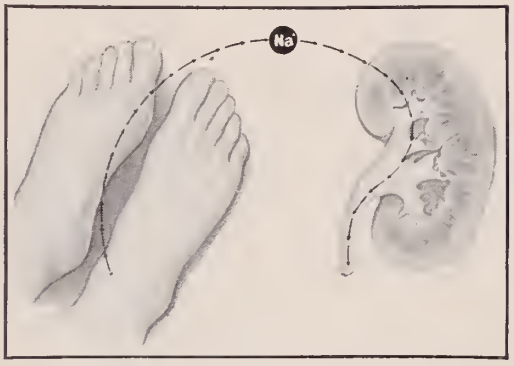
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Clinically, Mictine is useful in the maintenance of an edema-free state in all patients and for initial and continuing diuresis in mild or moderate congestive failure. It is not intended for initial diuresis in severe congestive failure unless either sensitivity or tolerance to other diuretics has developed in the patient.

The maintenance dosage of Mictine, as well as for initial diuresis in mild or moderate congestive heart failure, is one to four 200-mg. tablets daily in divided doses; the dosage for initial diuresis in severe congestive failure, under the conditions already described, is four to six tablets daily. For either use, it is recommended that Mictine be prescribed with meals on interrupted dosage schedules; that is, prescribing Mictine on alternate days or for three consecutive days and omitting it the next four days.

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COMPONENT SOCIETY NOTES

Alachua

Dr. Albert G. Love Jr., of Gainesville, is serving as president of the Alachua County Medical Society for 1956, having been chosen president-elect at the Society's annual meeting last year. Dr. Glenn O. Summerlin, of Gainesville, has been chosen president-elect; Dr. Henry S. Blank, vice president, and Dr. G. Leonard Emmel, secretary-treasurer. Both Dr. Blank and Dr. Emmel are from Gainesville.

Brevard

Dr. Isabel Roberts, of Melbourne, has been elected president of the Brevard County Medical Society. Dr. Myron L. Habegger, of Cocoa, has been chosen vice president, and Dr. Jack T. Bechtel, of Eau Gallie, secretary-treasurer.

Columbia

The Columbia County Medical Society has paid 100 per cent of its state dues for 1956.

Duval

Medical personnel from the Jacksonville Naval Air Station presented the program of the February meeting of the Duval County Medical Society. Each speaker gave his address as a case report.

Heading the list of speakers was Lt. E. H. Ruffolo who spoke on the subject "Hydatidiform Mole; Associated With Seven Months Pregnancy." Following Lt. Ruffolo was Cmdr. G. I. Walker whose topic was "Guillain-Barre Syndrome (Infectious Polyneuritis)," and concluding the program was Capt. F. V. Berley who spoke on "Traumatic Pneumothorax."

Lake

Dr. Turner Z. Cason, of Jacksonville, medical consultant for the State Department of Public Welfare; Mr. Charles G. Lavin, director, State Department of Public Welfare, and Mrs. Grace Stewart, director of the public assistance division of the Department, presented the program for the January meeting of the Lake County Medical Society.

The three speakers discussed in detail "The Program for the Indigent."

Madison

Dr. Candler K. Hayes has been elected president of the Madison County Medical Society for the year 1956. Dr. Wilmer J. Coggins will serve with Dr. Hayes as secretary. Both officers are from Madison.

Monroe

Dr. Allen Shepard is serving as president of the Monroe County Medical Society for 1956. He was installed at a January meeting of the Society. Dr. Robert W. Reid is serving with Dr. Shepard as vice president. Dr. William R. Ploss was re-elected secretary-treasurer. All the officers are from Key West.

Orange

Dr. James D. Moody, of Orlando, was principal speaker at the February meeting of the Orange County Medical Society. The subject of his address was "The Treatment of Cardiovascular Diseases and Aneurysms."

Pinellas

Dr. John P. Ferrell, of St. Petersburg, was principal speaker at the February meeting of the

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Composition	Per cent
Lignin, hemicellulose, pectin	22.0
Starch	15.0
Crude fiber	3.0
Soluble carbohydrates	50.5
Protein	3.5
Fat	0.5
Minerals	2.0
Moisture	3.5

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Pinellas County Medical Society. The subject of his address was "X-ray Interpretation." Dr. Frank T. Linz, of Tampa, and Dr. Irwin S. Leinbach, of St. Peterburg, were principal speakers at the Society's January meeting.

Putnam

Dr. Bennie J. Massey, of Palatka, is the new president of the Putnam County Medical Society. He was elected at the Society's recent annual meeting. Dr. Bernard E. Kane, of Crescent City, is serving with Dr. Massey as secretary-treasurer.

Sarasota

The Sarasota County Medical Society has been co-sponsoring with the Sarasota Herald-Tribune the first Medical Forums to be held in Sarasota. The concluding Forum took place February 10.

There were a total of four Forums, all on Friday nights and at intervals of one week. They were held in the City Auditorium.

Suwannee

Dr. Shirley L. Hadden, of Live Oak, has been elected president of the Suwannee County Medical Society. Dr. James A. Horten, also of Live Oak, will serve with Dr. Hadden as vice president. Dr. Hiram B. Curry, of Jasper, has been re-elected secretary-treasurer.

Walton-Okaloosa

Dr. Henry C. White Jr., of Fort Walton Beach, has been elected president of the Walton-Okaloosa County Medical Society. Dr. Howard A. Parker, of Valparaiso, has been chosen vice president, and Dr. George W. Barrow Jr., of Crestview, secretary-treasurer.

Three Pensacola physicians participated in a panel discussion on "Jaundice" at the Society's January meeting. They were Drs. Francis P. Cassidy; Barkley Beidleman and Nathan Arenson. Dr. William D. Cawthon, of DeFuniak Springs, served as moderator.

Washington-Holmes

Dr. Martin L. Lane, of Chipley, has been elected president of the Washington-Holmes County Medical Society. Dr. L. H. Paul, of Bonifay, will serve with Dr. Lane as secretary.

(Continued on page 762)

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*Lawrence, W. E.; Kahn, S. S., and Riser, A. B.: South. M. J. 47:105, 1954.

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(Continued from page 758)

St. Johns

Drs. William H. McCullagh and James G. Lyerly, of Jacksonville, were principal speakers on the Medical Forum held late in January at St. Augustine. The Forum was sponsored by the local Pilot Club with the cooperation of the St. Johns County Medical Society.

Taylor

Dr. Ralph J. Greene has begun serving as president of the Taylor County Medical Society. Dr. John H. Parker Jr. will serve with Dr. Greene as secretary. Both of the physicians are from Perry.

Medical Licenses Granted

Dr. Homer L. Pearson Jr., secretary of the State Board of Medical Examiners, has reported that of the 265 applicants who took the examination of the Board, held November 21 and 22, 1955, in Miami Beach, 202 passed and have been issued licenses to practice medicine in Florida. The names and addresses of the 202 successful applicants follow.

Anderson, Russell Lloyd, Jr., (Col.) Tallahassee (U. Pittsburgh 1955)
Andrejek, Arthur Raymond, Miami (U. Minnesota 1946)
Bachnik, Francis Wilfred, St. Petersburg (U. Minnesota 1937)
Ballard, William Crawford, St. Petersburg (South Carolina 1926)
Bean, Lewis Amos, Gallipolis, Ohio (U. Michigan 1946)
Belding, Warren Lewis, Jacksonville (Evangelists 1955)
Bell, William Reed, Pensacola (Duke 1953)
Bender, John Albert, Havertown, Pa. (Jefferson 1943)
Bennett, Louis Donald, Miami (Temple 1955)
Birner, Wolfgang Frederic, Miami (U. Kansas 1955)
Blevins, Sells, St. Petersburg (U. Tennessee 1955)
Blum, Edward Bernard, Williamsport, Pa. (Long Island 1943)
Boardman, Willard Harlow, Lancaster, N. Y. (U. Buffalo 1944)
Bogdonoff, Morton David, Durham, N. C. (Cornell 1948)
Boyles, Paul Weldon, Coral Gables (New York U. 1953)
Bramson, Morton Ben-Ari, Chicago (U. Illinois 1949)
Brenner, Robert Leonard Jr., Tampa (U. Kansas 1951)
Broadaway, Rufus Keene, Miami (Harvard 1950)
Brown, Harvey Earl Jr., Coral Gables (Marquette 1948)
Burns, James Patrick Jr., Winnebago, Neb. (Geo. Washington 1949)
Bussey, Dan Rockwell, Miami (Emory 1950)
Buttita, Richard Ignatius, Fort Lauderdale (Georgetown 1930)
Campbell, Lindsey Drayton, Chattahoochee (Bowman Gray 1947)
Cangelosi, John Thomas, Dunkirk, N. Y. (U. Buffalo 1936)
Carballo, Jose Domingo, Miami (U. Havana 1948)
Certo, Rocco Aurelio Gelsomino, North Miami (Boston P & S 1947)
Chenault, John Watson (Col.), Tallahassee (U. Minnesota 1931)
Clark, Albert Williams, Neptune Beach (U. Kansas 1942)
Clark, Eugene, New York (New York U. 1932)
Clayton, Malcolm Dexter Jr., Memphis, Tenn. (Emory 1945)

(Continued on page 766)

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Erythromycin in treatment of pyoderma*

8/12/55

DISCHARGE SUMMARY

Patient, white female, age 39, entered hospital with a diagnosis of lymphoma, proved to be lymphosarcoma by biopsy.

Initially she was treated by X-ray radiation, adrenal cortical hormone and an antinauseant. During this regimen she developed a generalized rash which became infected. This was a drug reaction with infection due either to (1) scratching or (2) a low WBC count due to radiation. A number of boil-like lesions appeared over the body.

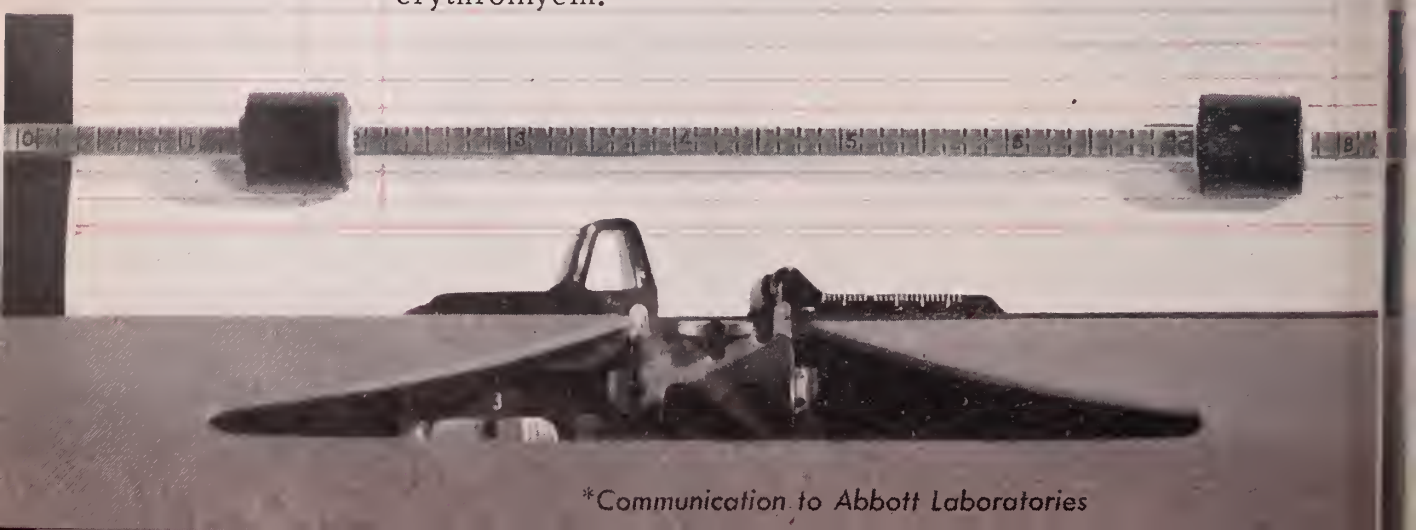
On 8/4 penicillin was started in a dosage of 600,000 units daily. Penicillin was continued for six days during which time the pyoderma became worse.

Aspirated material from the lesions yielded hem. S. aureus, coag. + and the following sensitivities were obtained: penicillin, more than 10 units; erythromycin, 10 mcg.; tetracycline, 50 mcg. When these results became available penicillin was discontinued.

On 8/9, erythromycin was started in a dosage of 200 mgm. q.i.d. Marked improvement was noted very soon and by 8/12 almost complete healing of all lesions had occurred. Patient was afebrile throughout.

Final Diagnosis: (1) lymphosarcoma (2) secondary pyoderma due to hemolytic Staphylococcus aureus.

Result: complete healing of secondary pyoderma with erythromycin.



*Communication to Abbott Laboratories

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Now, you can prescribe an antibiotic (*Filmtab* ERYTHROCIN) that provides *specific therapy* against staph-, strep- or pneumococci. Since these organisms cause most bacterial respiratory infections (and since they are the very organisms most sensitive to ERYTHROCIN) doesn't it make good sense to prescribe ERYTHROCIN when the infection is coccic?

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(Continued from page 762)

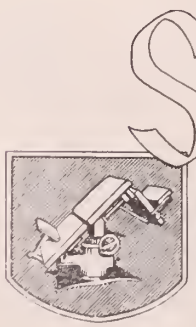
Cogan, Michael Aaron, Longmeadow, Mass. (Vanderbilt 1936)
Coleman, Hyron Evans (Col.), DeLand (Meharry 1955)
Couture, Walter Henry, St. Petersburg (McGill 1954)
Crews, Robert Lee, Key Biscayne (Vanderbilt 1954)
Cronick, Charles Herbert, Chattahoochee (U. Pennsylvania 1936)
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Cunningham, George Albert III, Oak Park, Mich. (Northwestern 1945)
Dalrymple, Richard Edward, Miami (Jefferson 1953)
Daniel, William Rogers, Orlando (Georgia 1948)
Day, James Fair, Chattahoochee (U. Pittsburgh 1952)
Demarais, Francis Emery, Tampa (U. Minnesota 1952)
DiLorenzo, Vincent James, Dundee (New York 1947)
Doane, Joseph Chapman, Madison, Wisc. (Temple 1948)
Dombroski, Walter Joseph, Miami (Temple 1955)
Draper, Bruce, Tampa (Yale 1954)
Eichert, Arnold Herman, Hollywood (U. Maryland 1938)
Erdman, Leonard Alfred, Miami (Jefferson 1950)
Evans, Warren Cavill, Asheville, N. C. (U. Virginia 1948)
Ewing, Richard Monterville, Cleveland (Tulane 1951)
Fabric, Ben Lue, Miami Beach, (Marquette 1935)
Flatt, Richard Stephan, Cincinnati (U. Cincinnati 1950)
Flowers, Neal Stewart, Marianna (Tulane 1952)
Fomon, John Joseph, Miami (Georgetown 1946)
Forthman, Hugh John, Miami (U. Cincinnati 1953)
Fowler, Nathaniel Eugene, Key West (U. Rochester 1946)
Francis, Lewis, Lexington, Ky. (Ohio State 1945)
Frazier, Archie Theopolis (Col.), Jacksonville (Meharry 1955)
Fusco, Ralph Joseph, Brookfield, Ill. (U. Chicago 1947)
Garland, John Courier, Elgin, Ill. (U. Illinois 1932)
Gates, Kermit Hoyt, Coral Gables (U. Iowa 1930)
Gessler, William Francis Jr., Miami (Indiana U. 1955)
Fixel, Irving Edwin, Miami Beach (Virginia 1943)
Gilpin, Charles Alexander Jr., Rosiclare, Ill. (U. Illinois 1949)
Gordon, Allan David, Miami (Columbia 1955)
Greenhill, Maurice Herzberger, Miami (U. Chicago 1936)
Greenwell, George Robert, Daytona Beach (U. Louisville 1955)
Grimes, Donald William, Palmetto (Tulane 1946)
Grimes, Harry Austin, Miami (U. Arkansas 1955)
Heffner, George Paul, Hialeah (Harvard 1934)
Heimer, William Lenox, Baltimore (U. Maryland 1952)
Henderson, Claude Brooks, Perry Point, Md. (U. Pennsylvania 1950)
Hendrix, Claude Addison Jr., Fort Lauderdale (U. Louisville 1947)
Hoffman, Erwin Prentice, Ann Arbor, Mich. (St. Louis 1950)
Holzberg, Stanley Irwin, Cincinnati (U. Cincinnati 1954)
Horwich, Harry, Biloxi, Miss. (U. Toronto 1948)
Jacobson, George, New Orleans (Louisiana State 1946)
Jeffrey, William Griffin, St. Petersburg (Wayne U. 1955)
Johannsen, Max Wilhelm, New York (New York U. 1935)
Johnson, Carl E., Rochester, Minn. (Northwestern 1946)
Jones, Edmund Lee Jr., Miami (U. Cincinnati 1954)
Jonsson, Ulfar, Miami (U. Iceland 1947)
Jowett, John Cecil, Miami (Northwestern 1953)
Kandzie, George John, Miami (Tufts 1955)
Kaplan, Alan Leslie, Miami (Columbia 1955)
Karol, Robert Stanley, Miami (State U. New York 1955)
Kascht, Robert Lawrence, Coral Gables (Northwestern 1948)
Kass, Paul, Miami Beach (U. Virginia 1928)
Kelly, Alexander Joseph Jr., Tampa (Long Island 1947)
Kelly, James Eweel, Daytona Beach (Bowman Gray 1953)
Kenneth, Milena Anna, North Miami (Paris 1951)
Kenney, Edward Christopher, Bethesda, Md. (U. Cincinnati 1930)
Kilpatrick, John Taylor, Montgomery, Ala. (Geo. Washington 1949)
King, William Bernard, Miami (Indiana U. 1949)
Kinloch, Everett Starke Jr., Miami (U. Vermont 1929)
Kirschenfeld, Jack J., Fort Deposit, Ala. (New York U. 1943)
Kohen, Roland Jay, Miami (Alabama 1949)

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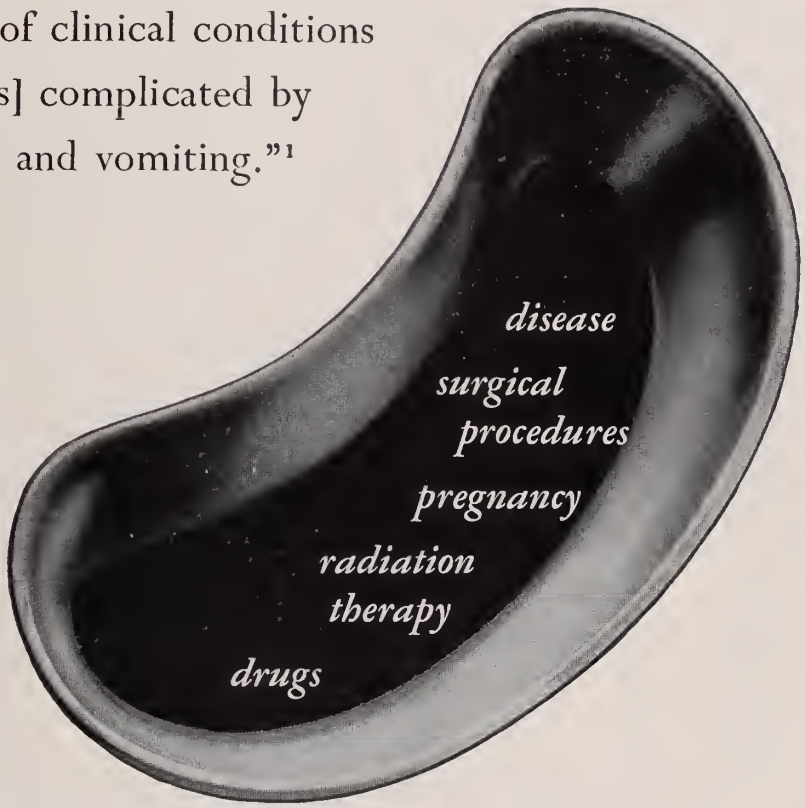
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Konstantinu, Ilias, Englewood (U. Innsbruck 1946)
Koval, John Myron, Cleveland (Jefferson 1947)
Kresler, Leon Eigelsbach, Winter Park (Indiana U. 1941)
Lanford, William Stanley, South Miami (Emory 1954)
Langley, Daniel Bernard, Naples (Georgetown 1934)
Larson, Eli, Miami (Tufts 1951)
Lawyer, Howard A., Jacksonville (U. Kansas 1954)
Lederman, Edward Isadore, Baltimore (U. Cincinnati 1941)
Lessner, Howard Edmond, Surfside (U. Pennsylvania 1953)
Levine, Oscar, Brooklyn (Beirut 1948)
Lewis, Lawrence Joyner, Miami (Bowman Gray 1953)
Long, Charles Whittington Jr., Miami (Geo. Washington 1954)
Long, Rolfe Dean, Tuckahoe, N. Y. (Columbia 1928)
Lord, Kurtland Herrick, Richmond, Va. (Boston U. 1949)
Lozman, Harvey, Miami Beach (Chicago 1949)
Mariash, Arnold David, Miami Beach (Southwestern 1951)
Martin, Richard Arthur, New Bedford, Mass. (U. Pennsylvania 1951)
McAllister, John Gordon, Miami (Georgia 1952)
McCall, John B. Jr., Jacksonville (Duke 1953)
McEuen, Harry Bernard Jr., Jacksonville (Temple 1954)
McGrady, Kathleen Reilly, Baltimore (U. Maryland 1951)
McKee, Thomas Vincent, Philadelphia (U. Pennslyvania 1953)
Merlin, Harvey Ernest, Brookline, Mass. (Emory 1955)
Miller, Hugh, Miami (Boston U. 1955)
Miller, Morton Larrimore, Miami (Ohio State U. 1946)
Mills, Bruce Ernest, West Palm Beach (Ohio State U. 1954)
Moore, John Clifton Jr., Lakeland (U. Louisville 1946)
Morris, Jim, Jacksonville (Georgia 1955)
Nelson, Robert Lee, Hialeah (Washington U. 1955)
Newhouser, Lloyd Russell, Coral Gables (Indiana U. 1924)
Nikolaus, Donald Gene, St. Petersburg (Ohio State U. 1955)
Nixon, Joseph Jefferson III, Jacksonville (Georgia 1955)
Norris, William Boone, St. Petersburg (U. Rochester 1955)
Norton, William James, Miami (U. Arkansas 1953)
Ohlmacher, Albert Philip, St. Simons Island, Ga. (U. Michigan 1922)
Oken, Donald Edward, Orlando (Columbia U. 1954)
Omainsky, Walter, Miami (Vanderbilt 1954)
Orebaugh, John Edwin, Ann Arbor, Mich. (U. Michigan 1944)
Ostling, Burton Charles, Avon Park (U. Michigan 1948)
Pavlin, Otto Bohumil, Bradenton Beach (U. Illinois 1925)
Peters, McHenry Jr., Lynchburg, Va. (U. Pennsylvania 1954)
Prenzler, Lyle Howard, Bloomington, Ill. (U. Illinois 1946)
Prescott, Blake Daniels, Springfield, Mass. (Middlesex U. 1931)
Price, Ira Burton, Quincy (Western Reserve 1953)
Rabkin, Richard, Miami Beach (Ohio State U. 1955)
Ratke, Henry Victor, Williamsport, Pa. (Jefferson 1941)
Reese, Howard Lanier, Philadelphia (U. Pennsylvania 1948)
Reiff, Max Henry, Bronx, N. Y. (New York Homeo 1932)
Reilly, Carl Nelson, Winter Haven (U. Illinois 1945)
Reinoehl, Michael Orr, Coral Gables (U. Pennsylvania 1955)
Relkin, Gerald, Brooklyn (State U. New York 1953)
Reynolds, James Eugene, Chattanooga, Tenn. (U. Tennessee 1952)
Roche, Thomas White, Miami (U. Michigan 1953)
Rogers, Alexander Sidney, Coral Gables (Middlesex U. 1943)
Rosen, Sigmund Joseph, Brooklyn (State U. New York 1952)
Rubinstein, Lee Irwin, Miami (Western Reserve 1953)
Rubio, Manuel Francisco, Tampa (U. Havana 1942)

(Continued on page 774)

THORAZINE*

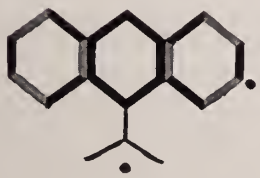
"An effective antiemetic agent for a wide range of clinical conditions [and situations] complicated by nausea and vomiting."[1]



1. Moyer, J.H., et al.: Arch. Int. Med. 95:202 (Feb.) 1955.

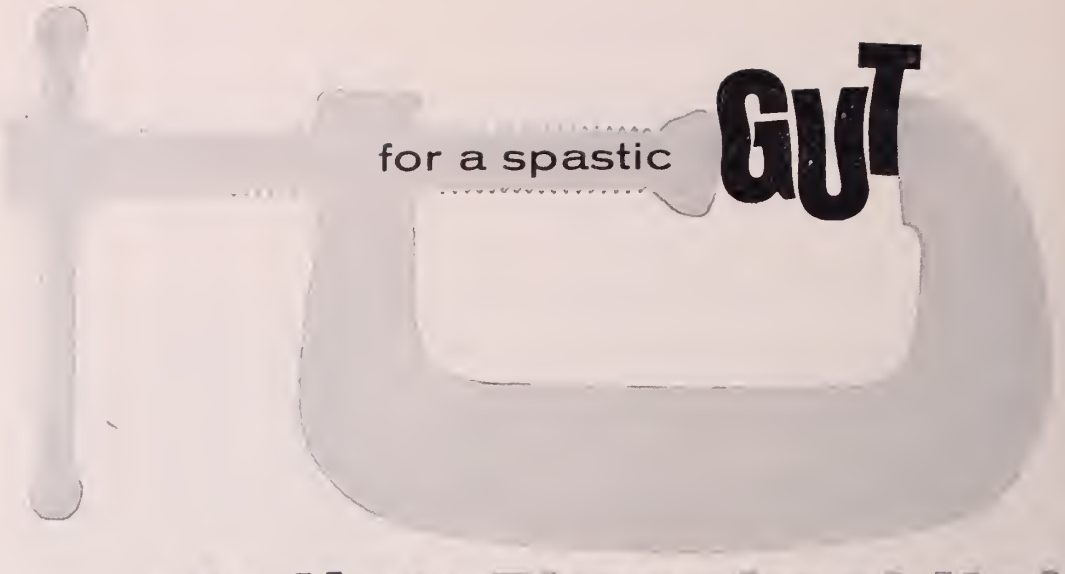
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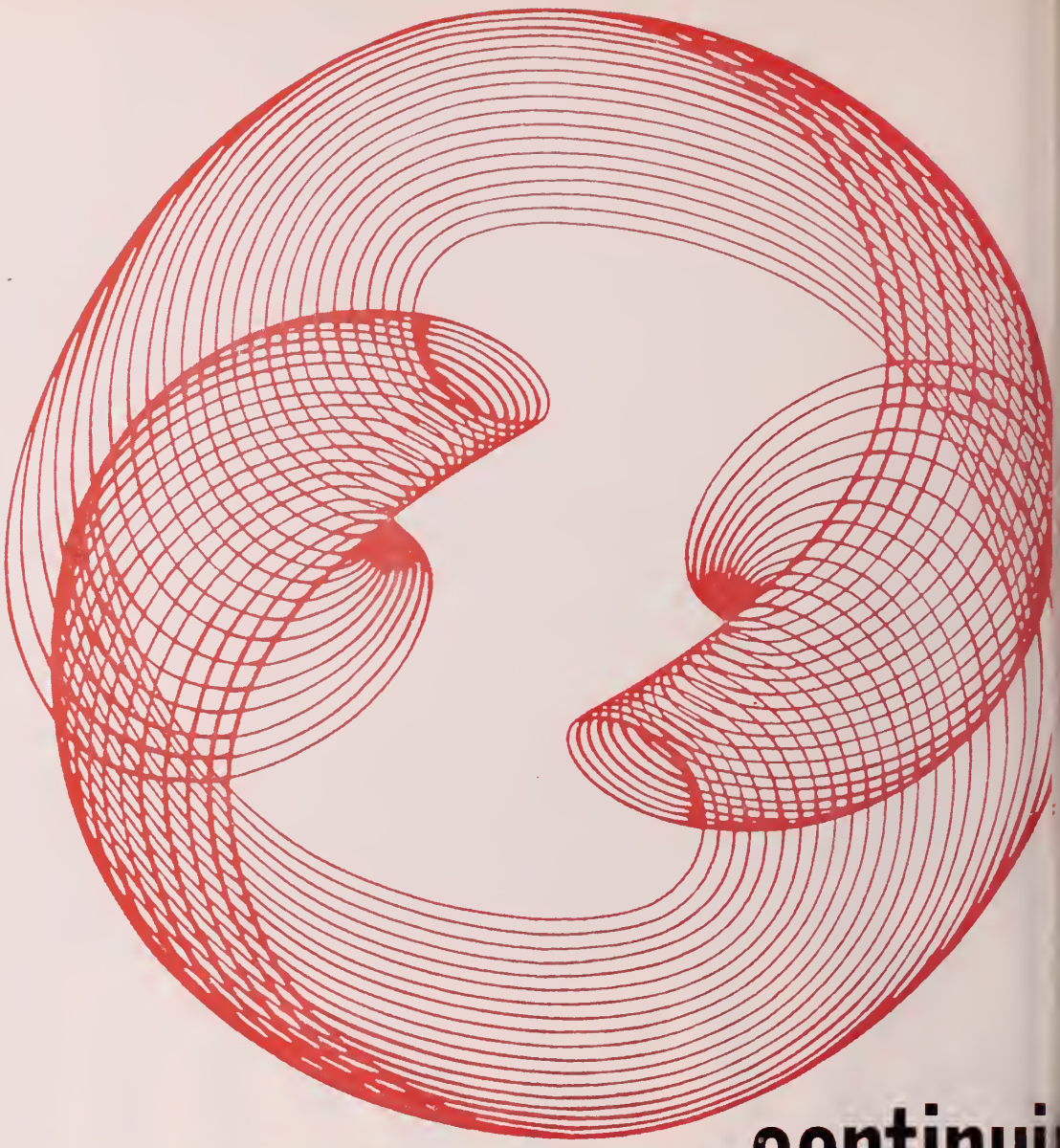
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References: 1. Bunim, J. J., et al.: J.A.M.A. 157:311, 1955. 2. Forsham, P. H., et al.: Paper presented at First Internat. Conf. on Prednisone and Prednisolone, New York, May 31-June 1, 1955. 3. Perlman, P. L., and Tolksdorf, S.: Scientific Exhibit presented at A.M.A. Annual Meet., Atlantic City, June 6-11, 1955.

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc. Brooklyn 6, New York

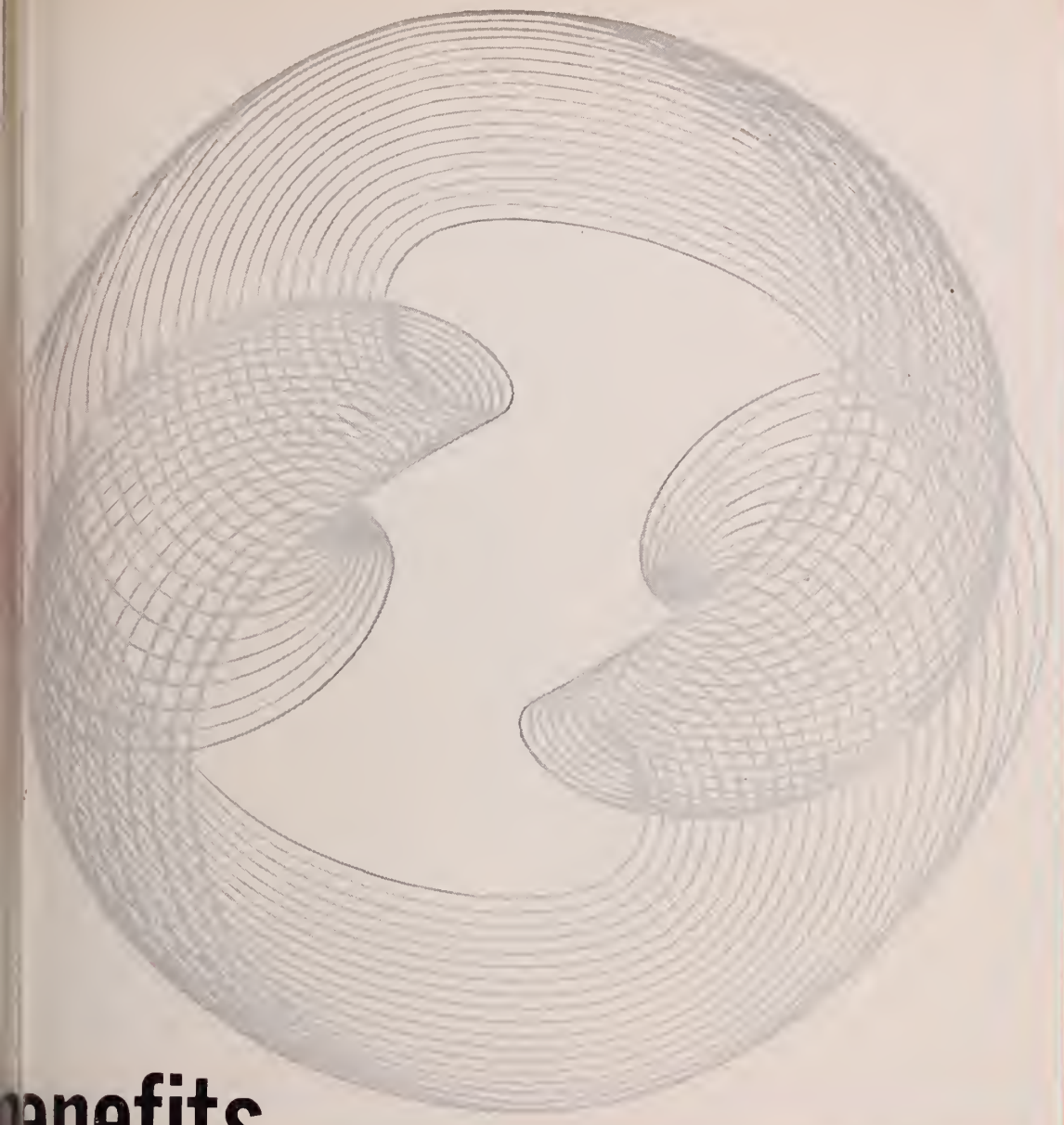
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(Continued from page 768)

Schiess, Robert John Jr., Miami (Bowman Gray 1954)
Schlaepfer, Karl Frederick Jr., Miami (Temple 1954)
Schoeffel, Michael Eugene, Chicago (Loyola 1953)
Schotz, Sylvan Art, Coral Gables (State U. New York 1952)
Schwartz, Robert Carl, Syracuse, N. Y. (Syracuse U. 1932)
Schwenker, Harry Frederick Jr., Jacksonville (U. Texas 1946)
Scott, Thomas Elmer Jr., Daytona Beach (U. Tennessee 1945)
Sendker, Raymond William, Buffalo (U. Buffalo 1924)
Shafer, Nathaniel, Brooklyn (New York U. 1954)
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Siers, Mary Rose, Largo (Vanderbilt 1954)
Smith, James Edgar, Jacksonville (Bowman Gray 1952)
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Stein, Sigmund, Miami (U. Buffalo 1955)
Stephenson, Samuel Edward Jr., Nashville, Tenn. (Vanderbilt 1950)
Swan, Daniel Mason, Quincy, Mass. (U. Rochester 1935)
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Thames, Thomas Byron, Miami (Duke 1955)
Tomlinson, John Lewis, Pompano Beach, (Hahnemann 1944)
Truppman, Edward Stanley, Miami (U. Minnesota 1955)
Tully, George Thomas, Jacksonville (U. Rochester 1954)
Uhr, Jonathan William, New York (New York U. 1952)
Uzmann, John William, Jacksonville (Georgetown U. 1945)
vanBoven, John III, Detroit (U. Michigan 1950)
Vargas, Alvaro, Miami (Mexico 1949)
Vaujin, Octavio Augusto, Miami Beach (U. Havana 1949)
Walker, Bruce Elwin, St. Petersburg (U. Tennessee 1955)
Wall, Bithel, Sylvester, Ga. (U. Georgia 1946)
Walls, William Leslie, Miami (Temple 1955)
Wargo, John Donald, Miami (Temple 1955)
Warren, Donald Eugene, Atlanta, Ga. (Duke 1952)
Watt, Francis Hansell, Thomasville, Ga. (Johns Hopkins U. 1948)
Wayburn, Gates Jordan, Huntington, W. Va. (Emory 1934)
Weber, Robert George, Rochester, Minn. (Northwestern 1950)
Wells, Marion Francis, St. Petersburg (U. Virginia 1954)
Wherry, Curtis Gill, Coral Gables (U. Tennessee 1951)
Whitcomb, John Howard, Roxbury, Mass. (Harvard 1953)
White, Walter Motley Jr., St. Petersburg (U. Virginia 1943)
Widrich, Jack, Miami Beach (Ohio State U. 1934)
Williams, Dana Steeves, Brandon (Duke 1955)
Williams, Richard David, Palmerton, Pa. (Hahnemann 1943)
Wilson, Theodore Warren, Rochester, Minn. (U. Minnesota 1948)
Wolf, Richard Stanley, Cincinnati (U. Cincinnati 1954)
Woods, Alexander Hamilton, Durham, N. C. (Johns Hopkins 1952)
Woods, Paul Hutcheson, Orlando (U. Arkansas 1943)
Young, Gregory George, Miami (U. Cincinnati 1955)
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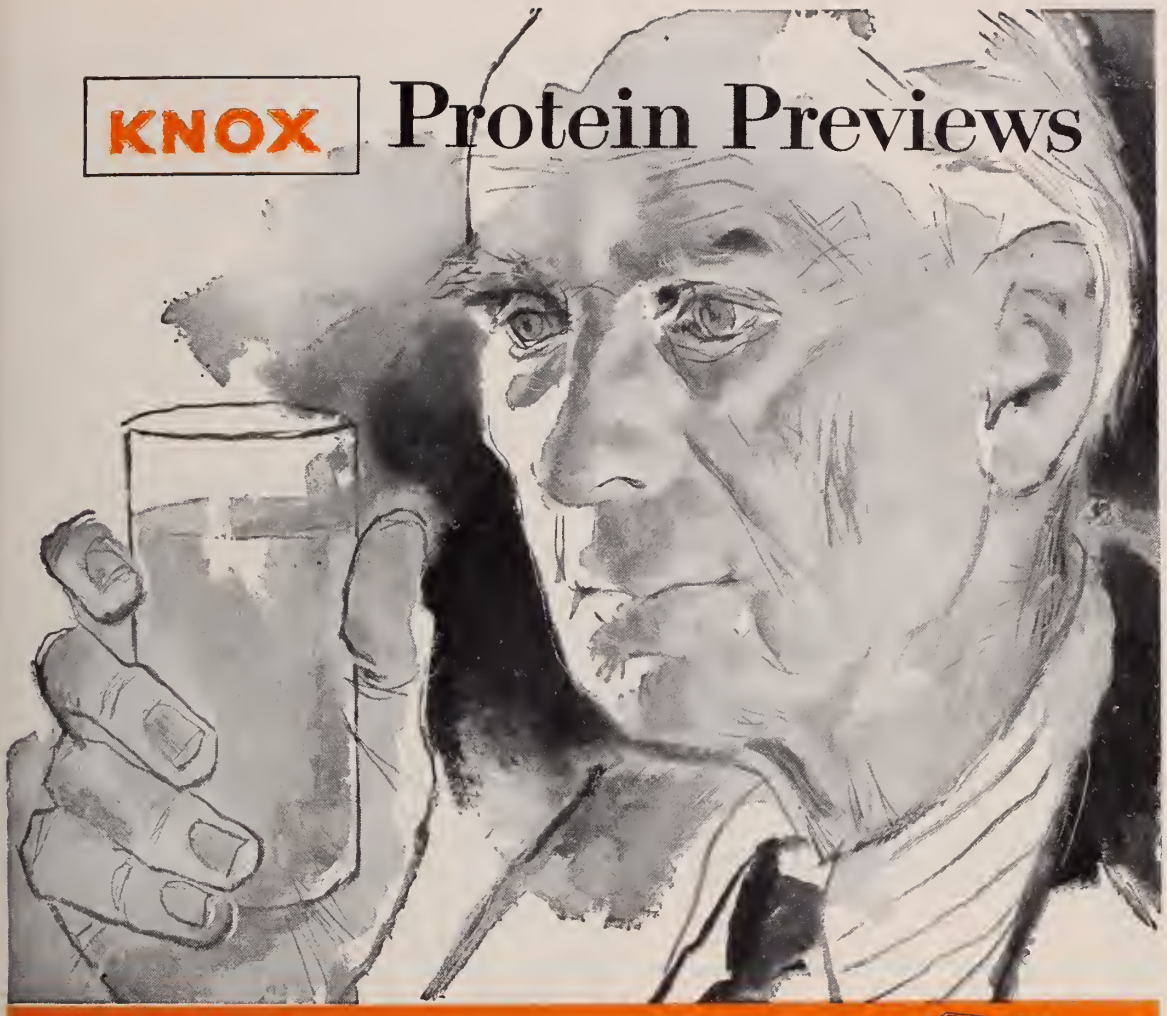
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Professional Service Department, SJ-15
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***"Real* coffee**—delicious coffee!" Such was your enthusiastic comment at medical conventions—when you tasted Instant Sanka at the Instant Sanka booth.

And, Doctor, you couldn't be more right. Since only the caffein has been removed from Instant Sanka Coffee, all the pure coffee goodness is there for you to enjoy.

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INSTANT SANKA COFFEE



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97% caffein-free

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Meat...

and the Value of Fat in Nutrition

Authorities in the field of nutrition no longer consider fat as an optional component of the diet. Evidence from the laboratory and bedside indicates that fat in small amounts may be looked upon as an obligatory constituent of a health-promoting diet.[1]

The far-reaching value of fat in nutrition has been amply demonstrated in laboratory animals in its pronounced effect on growth, on pregnancy and lactation, on nitrogen-sparing action, on work capacity, on time of sexual maturity, on the period of survival during fasting, and on ability to combat external stresses.[1]

Young animals fed a fat-free diet not only fail to grow normally, but develop hair and skin changes characteristic of "essential" fatty acid deficiency.[2] Fatty acids other than the "essential" fatty acids also appear to be necessary for optimal health. Animals fed "essential" fatty acids but no others do not grow optimally.

The value of fat in human nutrition was emphasized in a recent study[2] comprising 200 patients incapable of receiving adequate nourishment. For periods of 1 to 30 days, these patients were given supplementary fat alimentation by vein in the form of fat emulsion containing "essential" as well as other fatty acids. The result was typically a marked increase in weight and more positive nitrogen and potassium balances.

Meat, recognized for its high content of biologically valuable protein, B vitamins, and essential minerals, provides, in addition, substantial amounts of nutritionally important fat.

1. Deuel, H. J., Jr.: Newer Concepts of the Role of Fats and of the Essential Fatty Acids in the Diet, Food Res. *20*:81 (Jan.-Feb.) 1955.

2. Meng, H. C.: Preparation, Utilization, and Importance of Neutral Fat Emulsion in Intravenous Alimentation, in Najjar, V. A.: Fat Metabolism, Baltimore, The Johns Hopkins Press, 1954, pp. 69-92.

The nutritional statements in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

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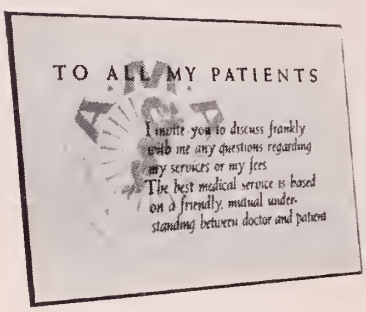
sure to make a hit with your patients by providing written answers to many questions about their medical care.

AMA now offers you its newest publication designed as a PR adjunct to your medical practice. TO ALL MY PATIENTS is just one of several public relations pieces recently developed by AMA to help you and your patients achieve that mutual understanding so important to a successful doctor-patient relationship. This attractive 12-page pamphlet—which was mailed to all AMA members—briefly describes the responsibilities of various persons on the medical team . . . discusses medical and hospital fees and health insurance . . . and encourages a friendly discussion of medical services and fees.

TO ALL MY PATIENTS begins: "I appreciate the confidence you have expressed in me by selecting me as your physician. I sincerely hope that I can give you and your family the kind of medical service you desire. . ."

TO ALL MY PATIENTS concludes: "It is difficult for a physician briefly to explain every service necessary in providing good care because each case is different. I sincerely hope this leaflet will give you a better understanding of some of the services you may require. . ."

For that added personal touch, space has been provided on the back cover for you to imprint or stamp your name. Quantities of TO ALL MY PATIENTS may be secured free of charge from the American Medical Association by sending in the coupon below.



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HydroCortone® -T B A

(HYDROCORTISONE TERTIARY-BUTYLACETATE, MERCK)

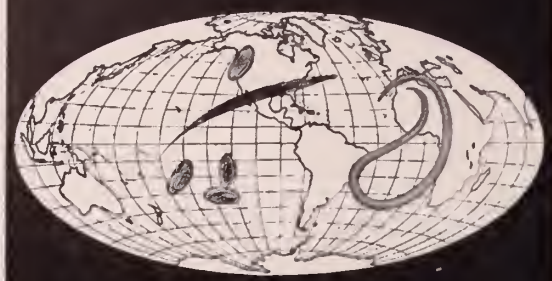
gives the arthritic patient more days of freedom from joint symptoms—in many patients the anti-rheumatic effect persists 2 to 10 times longer than after injection of hydrocortisone acetate. Its action is local and without systemic effect.

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ROUNDWORMS

*SYRUP OF 'ANTEPAR' Citrate brand Piperazine Citrate

Bottles of 4 fluid ounces, 1 pint and 1 gallon.

*TABLETS OF 'ANTEPAR' Citrate brand Piperazine Citrate

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Bottles of 100.

Pads of directions sheets for patients available on request.

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Introduction

At the annual conference of the Woman's Auxiliary to the American Medical Association, Mrs. Aaron Margulis, president, Woman's Auxiliary to the New Mexico Medical Association, spoke on the Mental Health Panel under the topic "What Mental Health Means to the Individual Doctor's Wife." It was our feeling that her talk was so true and pertained so well to mental health of the doctor's wife that by reprinting it on our page in the Florida Medical Journal we might be able to give the doctors a better perspective and greater understanding of their wives. So, here is the talk that Mrs. Margulis gave, we are greatly indebted to her for its use.

Mrs. Richard F. Stover

What Mental Health Means to the Individual Doctor's Wife

The obvious value of good mental health to any individual is that it means the difference between success and failure in the effectiveness of the roles one must assume in his life.

Our first responsibility is usually that of motherhood. In this enlightened and complicated age each parent is charged with rearing children who are socially responsible, intellectually cultivated and emotionally mature citizens; this challenge is shared by all mothers, but wives of doctors, unlike most other wives, have the pleasure of accomplishing the task alone. True, the children have the vital father image, but, like most images, he remains

remote and worshipped from afar. Medicine is a stern taskmistress, and the only contact between father and child, day after day, is usually the sound of the tires of daddy's car scrunching to a halt in the driveway after the child is in bed for the night, and the sound of them squealing out again in the early morning before anyone is up, in answer to the relentless telephone.

Perhaps the most complicated role that we play is that of wife. There was a president of a State Auxiliary whose theme for the year was "How lucky we are to be married to doctors!" I often thought that this categorical statement would be more accurate if it had been shortened to "How lucky we are to be married," for, save perhaps for ministers' wives, no group of women have heavier obligations in their marriages than we who are married to physicians.

In the first place, our conduct must be irreproachable at all times; Caesar's wife had nothing on the modern doctor's wife! Not for us is the light flirtation at the country club on Saturday night to reassure ourselves that we are still attractive to men; this is an assault on the dignity of our households, and this is forbidden in spite of the fact that we attend practically all social events unescorted. Neither may we ease the tensions of an impossible day with two or three cocktails, for the doctor's wife must save her husband from the ignominy of having his wife's name brandied about as one who drinks too much.

The doctor's wife must at all times dress well and look serene, and keep her husband and children and household looking prosperous, no matter what the state of the family exchequer, for no one wants to go to a doctor who isn't successful. At the same time, she must observe a very fine line between looking prosperous and looking too prosperous, lest the local gossips whisper that her husband's fees are outrageous.

She must ever be the soul of discretion; as far as the illnesses of her nearest and dearest friends, and every one else, is concerned, she must be the very last to know that the illness exists and, especially, what the diagnosis is. This leads to some strange situations, naturally; one's best friend may be in a hospital recovering from a mastectomy which one's own husband had performed, but until a nonmedical source informs her, the surgeon's wife stays anxiously by waiting to hear the news. A considerate husband does not tell his wife a single medical tidbit and saves her from the temptation of knowing too much.

Nor do medical ethics allow her to enter into that favorite pastime of other women, bridge table evaluations of how good one or another of her husband's colleagues is, and how wise or foolish the treatment he gives. She must not repeat any of her favorite medical folklore; in fact, it is helpful if she is a walking handbook on anatomy, physiology, pathology and pharmacology, for every treasured old wife's tale gleaned in childhood from a wise nurse, repeated by her, becomes at once the medical law and gospel, straight from the horse's mouth, once removed. (Only a faithful reader of *Today's Health* is equipped to enter into objective medical discussions on social occasions.)

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Bumbalo, T. S., Gustina, F. J., and Oleksiak, R. E.: J. Pediat. 44:386, 1954.

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Brown, H. W.: J. Pediat. 45:419, 1954.

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Ordinary mortals indulge in a little wholesome hypochondriasis, forbidden to those married to the profession. The poor doctor's wife, stricken with a set of symptoms corresponding exactly to those of the rare liver disease she heard her husband discussing the week before, suffers them in silence, or with only mild complaint, until they go away, for she must not clutter up the waiting rooms of her husband's colleagues; after all, she isn't a paying patient! It seems, too, that the only treatment in her husband's armamentarium, as far as his family is concerned, is "take a couple of aspirin, and get some rest," no matter what the affected area or the symptoms affecting it.

In addition to the personal limitations, the doctor's wife has the primary obligation of being always cheerful, sympathetic and encouraging to her husband engaged in a profession that makes overwhelming demands on him, both physically and spiritually.

In the community, the doctor's wife is the model of the good citizen. Every voluntary health agency, church, youth-serving and cultural organization looks first to her for volunteer help. The Junior League occupies her until she is 40, then she graduates to a sort of mystical Senior League composed of all the agencies eager to claim the four hours of volunteer "leisure" left by the void. At the same time, she must appear to put her children, home and husband, first, and never neglect them. It is sometimes a brutal fact that she must put *everything* first.

While she rides the civic and social merry-go-round, the doctor's wife must also be informed on economic, political and social matters, and sincerely concerned for the problems in these fields, whether they are local, national or international. She must conduct her own life and direct the lives of her family in the knowledge that sound society begins at home, and that "political and economic evils arise out of the befuddled and distorted minds and hearts of men."

Karl Menninger has set a measure of mental health for everyone: "Maintain an even temper, an alert intelligence, socially considerate behavior and a happy disposition." This is our challenge, all this. . . .and be a doctor's wife, too!

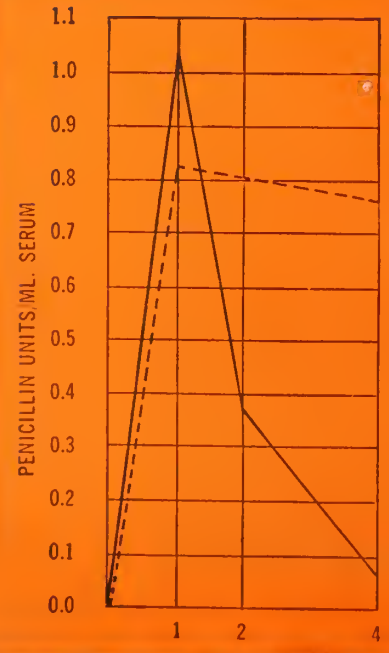
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Ageing — General Aspects. Ciba Foundation Colloquia on Ageing, Volume 1. Editors for the Ciba Foundation, G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Margaret P. Cameron, M.A., A.B.L.S., Pp. 225. Price, $6.75. Boston, Little, Brown and Company, 1955.

The papers and discussions in this book represent the proceedings of the first of a new series of conferences undertaken in 1954 by the Trustees of the Ciba Foundation, designated "Colloquia on Ageing" and intended to lend support, internationally, to basic research relevant to the problems of ageing. This colloquium was planned to be a general exploration and appreciation of the present position in regard to opinion and experiment on the processes associated with or directly involved in the changes occurring in tissues with age, at whatever period of life of the organism from conception to death.

This scientific approach of highest order, presented by an international group of distinguished authorities, is both informative and stimulating. A partial table of contents includes such subjects as the definition and measurement of senescence, the pathologic basis of ageing, mental aspects, effects of ageing on respiratory function, ageing of elastic tissue, calcium metabolism in old age, tissue transplantation technic, preservation of tissue, gerontology nutrition, too rapid maturation in children, psychologic aspects, adrenocortical reactivity in aged schizophrenic patients, vascular lesions of the skin, and 17-ketosteroid excretion.

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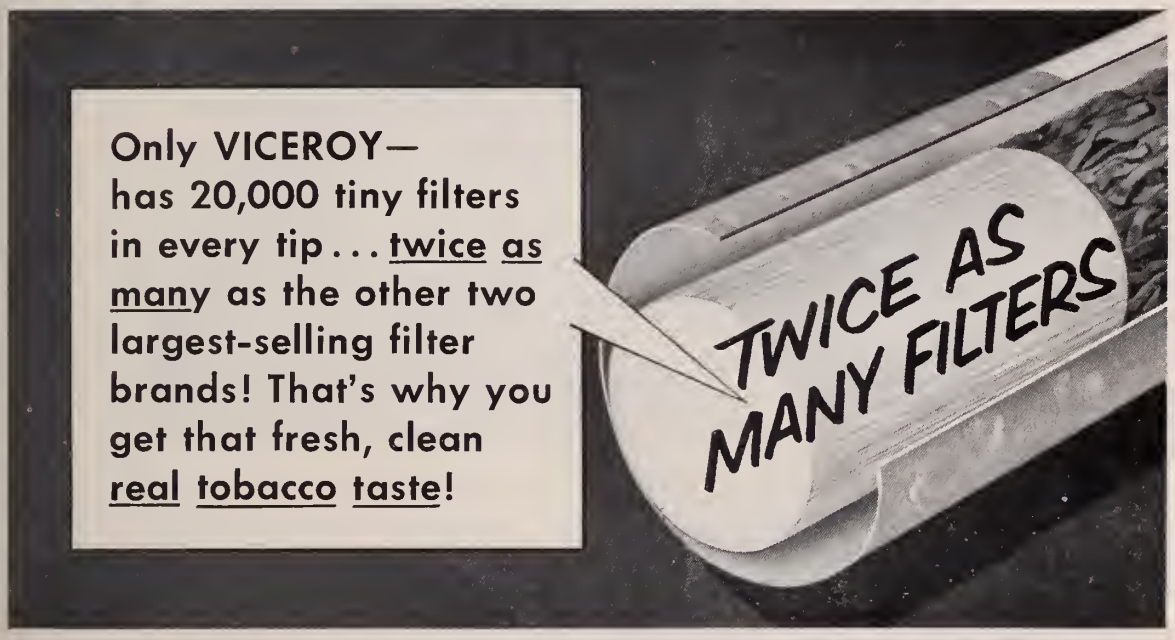
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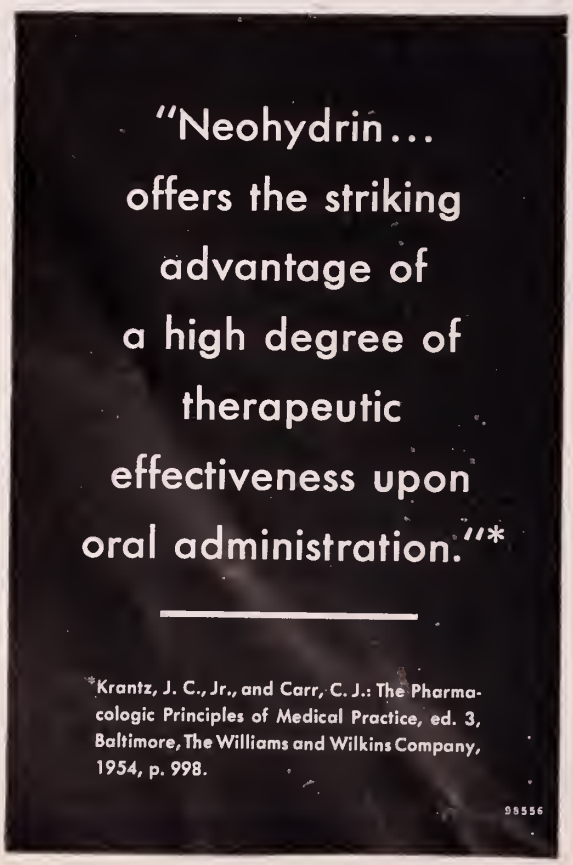
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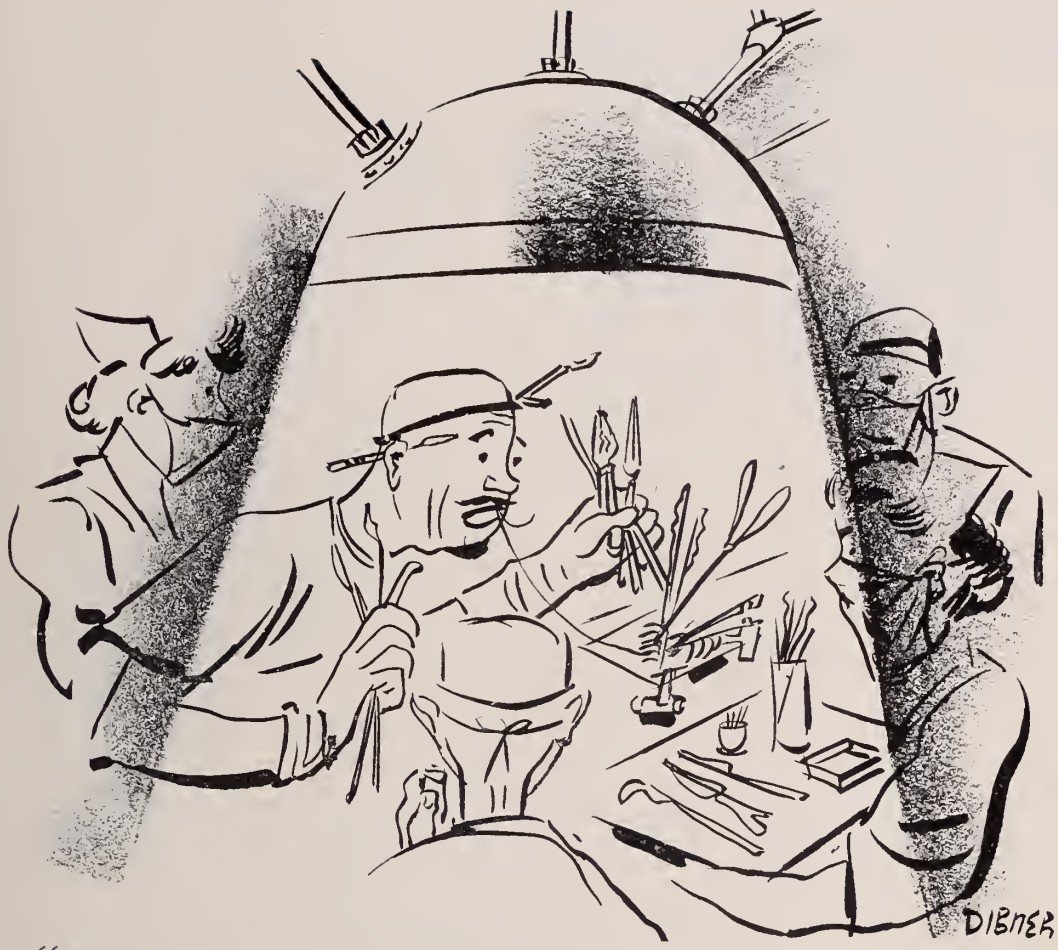


Preventive Medicine in World War II. Volume II. Environmental Hygiene. Editor in Chief, Colonel John Boyd Coates, Jr., MC; Editor for Preventive Medicine, Ebbe Curtis Hoff, Ph.D., M.D. Pp. 404. Washington, D. C., Office of the Surgeon General, Department of the Army, 1955.

This volume is one of the Preventive Medicine series of the history of the Medical Department of the United States Army in World War II. It is concerned with environmental hygiene and its impact upon the health, well-being, and morale of the United States Army personnel during this war. Its purpose is to record those plans, operations, and activities which utilized, modified, or controlled environment for health purposes. Accomplishment and failures have been of equal concern. The necessity for careful analysis and evaluation has been paramount in the minds of the authors and reviewers. No attempt has been made to chronicle the minutiae of the practice of environmental hygiene by theater. The scope of the problem was global. Emphasis, therefore, has been placed upon principles and practices peculiar to areas of the world and the impact of the circumstances under which it was necessary to operate.

As stated in the Foreword, the book emphasizes in large part the major issues which confronted "top level" personnel and the specific measures taken. The planning, implementation, and monitoring of the major health measures required and undertaken in conjunction with an unprecedented mobilization and global employment of the Army are emphasized, particularly from the sanitary engineering viewpoint. The volume as a whole is inspirational and a tribute to those who served so faithfully and with such success. It should be of interest to thousands of physicians and those in the allied sciences who have served or may be called upon in the future to serve in the United States Army.

Volume I, Organization and Administration of the Preventive Medicine Program, is being prepared and should be available in the near future.



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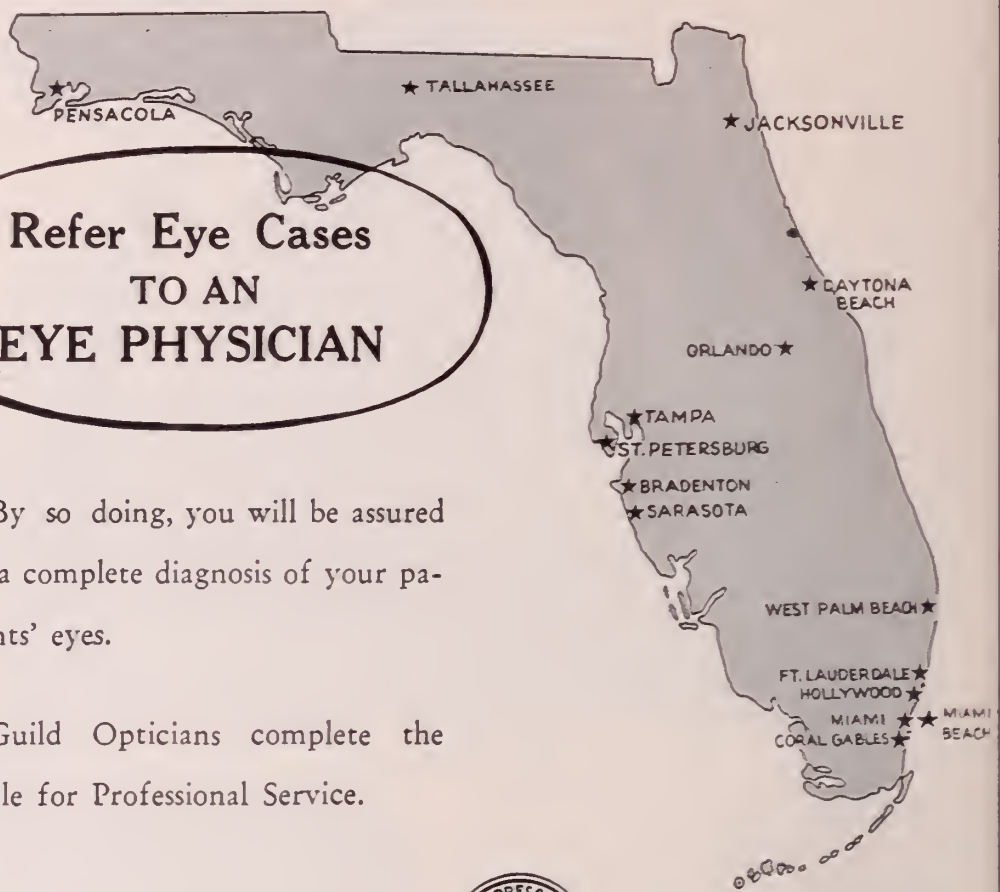
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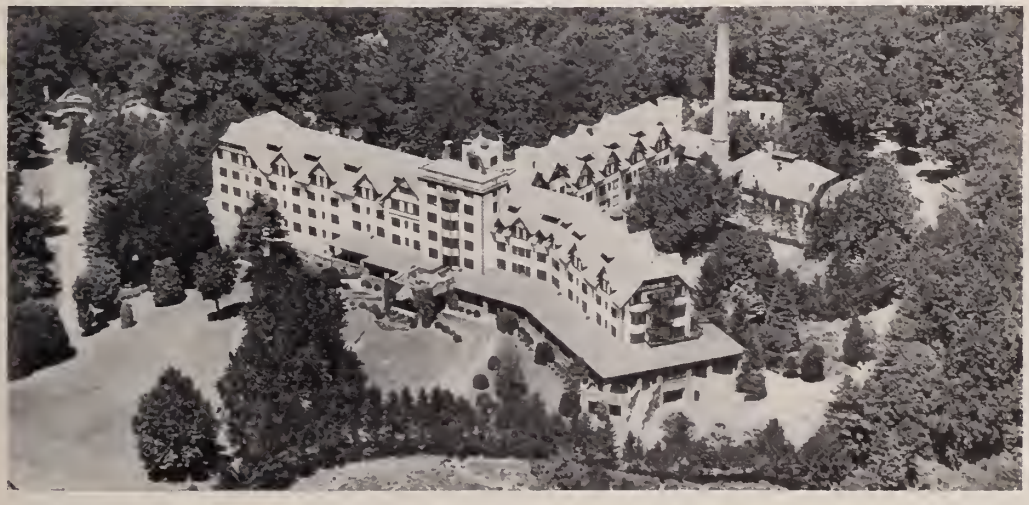
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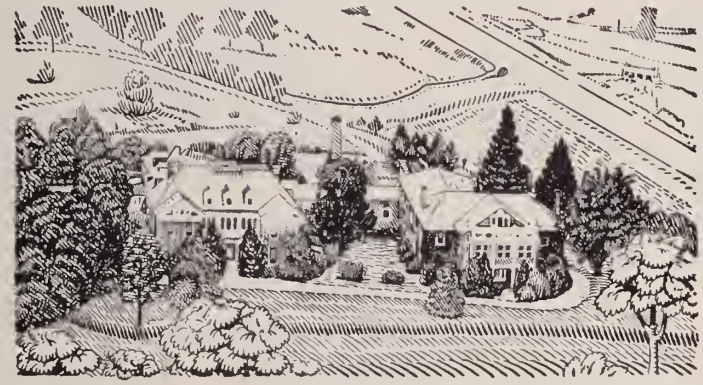
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ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Medical Association	John D. Milton, Miami	Samuel M. Day, Jacksonville	Miami Beach, May 13-16, '56
Medical Districts	Ralph W. Jack, Miami	Council Chairman	
orthwest	William P. Hixon, Pensacola	Walter J. Baker, Foley	Tallahassee
ortheast	Henry J. Babers Jr., Gainesville	Charles L. Park Sr., Sanford	Ocala
uthwest	C. Frank Chunn, Tampa	James R. Boulware Jr., Lakeland	Tampa
utheast	James R. Sory, West Palm Beach	Ralph S. Sappenfield, Miami	West Palm Beach
Specialty Societies			
y of General Practice	Frank T. Linz, Tampa	James B. Hodge Jr., Tampa	Miami Beach, May 13, '56
Society	W. Ambrose McGee, W. P. Bch.	Norris M. Beasley, Ft. Lauderdale	" " " "
siologists, Soc. of	Wayland T. Coppedge Jr., Jax.	John T. Stage, Jacksonville	" " " "
hys., Am. Coll., Fla. Chap.	Hawley H. Seiler, Tampa	William L. Potts, Lantana	" " " "
and Syph., Assn. of	Joseph L. Hundley, Orlando	Kenneth J. Weiler, St. Petersburg	Miami Beach, May 12-13, '56
Officers' Society	Clarence L. Brumback, W. P. Bch.	Lorenzo L. Parks, Jacksonville	Miami Beach, May 13, '56
ial and Railway Surgeons	Frank L. Fort, Jacksonville	John H. Mitchell, Jacksonville	" " " "
gy & Psychiatry	Edward H. Williams, Miami	J. Robert Campbell, Tampa	Miami Beach, May 12-13, '56
Gynec. Society	J. Champneys Taylor, J'sonville	Reuben B. Chrisman Jr., Miami	Miami Beach, May 13, '56
l. & Otol., Soc. of	Charles W. Boyd, Jacksonville	Keneth S. Whitmer, Miami	" " " "
dic Society	Edward W. Cullipher, Miami	Robert P. Keiser, Coral Gables	" " " "
gists, Society of	Millard B. White, Sarasota	Wray D. Storey, Tampa	" " " "
c Society	Wesley S. Nock, Cor Gbls	Henry G. Morton, Sarasota	" " " "
gic Society	Thomas F. Nelson, Tampa	George Williams Jr., Miami	Miami Beach, May 12, '56
gical Society	Hugh G. Reaves, Sarasota	Donald H. Gahagen, Ft. Laud'dale	Miami Beach, May 12-13, '56
s, Am. Coll., Fla. Chapter	Joseph S. Stewart, Miami	C. Frank Chunn, Tampa	Miami Beach, May 13, '56
cal Society	David W. Goddard, Daytona Bch.	W. Dotson Wells, Fort Lauderdale	" " " "
—			
Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Miami, June 9, '56
Banks, Association	Louis E. Pohlman, Orlando	Mrs. Estelle Lieberman, W. P. Bch.	Pensacola, May 26-27, '56
Cross of Florida, Inc.	Mr. C. DeWitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	
Shield of Florida, Inc.	Russell B. Carson, Ft. Lauderdale	John T. Stage, Jacksonville	Jacksonville, Apr. 20, '56
r Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	Miami Beach, May 13, '56
al Diabetes Assn.	Sidney Davidson, Lake Worth	Edward R. Smith, Jacksonville	
l Society, State	T. A. Price, D.D.S., Miami	W. A. Buhner, D.D.S., Daytona B.	Miami Beach, May 28-30 '56
Association	Victor H. Kugel, Miami Beach	Edwin P. Preston, Miami	Miami Beach, May 9-12, '56
tal Association	Mr. Pat N. Groner, Pensacola	Mr. Steve F. McCrimmon, C. Gbls.	
al Examining Board	Morris B. Seltzer, Daytona Bch.	Homer L. Pearson Jr., Miami	Miami Beach, June 24-26, '56
al Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 25-29, '56
Anesthetists, Fla. Assn.	Miss Dorothy Jackson, C. Gables	Mrs. Lulla F. Bryan, Miami	June 24-26, '56
s Association, State	Martha Wolfe R.N., Coral Gables	Agnes Anderson, R.N., Orlando	
naceutical Assoc., State	Miss Frances Walpole, Sarasota	Mr. R. Q. Richards, Ft. Myers	Clearwater, May 20-23, '56
Health Association	L. L. Parks, Jacksonville	N. J. Schneider, Ph.D., Jax	Jacksonville, Apr. 12-14, '56
au Society	Harold W. Johnston, Orlando	Howard M. DuBose, Lakeland	Jacksonville, Apr. 12-14, '56
culosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mr. Ernest L. Abel, W. Palm Bch.	Jacksonville, Apr. 12-14, '56
an's Auxiliary	Mrs. Samuel Lombardo, J'sonville	Mrs. Leffie M. Carlton Jr., Tampa	Miami Beach, May 13-16, '56
n Medical Association	Elmer Hess, Erie, Pa.	Geo. F. Lull, Chicago	Chicago, June 11-15, '56
A. Clinical Session	Elmer Hess, Erie, Pa.	Geo. F. Lull, Chicago	Seattle, Nov. 27-30, '56
n Medical Association	W. Ray McKenzie, Balti., Md.	Mr. V. O. Foster, Birmingham	Washington, Nov. 12-15, '56
n Medical Association	F. L. Chenault, Decatur	Douglas L. Cannon, Montgomery	Birmingham, Apr. 19-21, '56
Medical Assn. of	H. Dawson Allen Jr., Milledgeville	David Henry Poer, Atlanta	Atlanta, May 13-16, '56
ospital Conference	Mr. D. O. McClusky Jr. Tuscaloosa, Ala.	Mr. Pat Groner, Pensacola	Miami Beach, Apr. 18-20, '56
stern Allergy Assn.	Ben Miller, Columbia, S. C.	Kath. B. MacInnis, Columbia, S.C.	Charlotte, N. C., Oct. 5-6, '56
stern, Am. Urological Assn.	Sidney Smith, Raleigh, N. C.	Robert F. Sharp, New Orleans	Hollywood, Mar. 25-29, '56
stern Surgical Congress	Donald S. Daniel, Richmond	B. T. Beasley, Atlanta	Richmond, Mar. 12-15, '56
ast Clinical Society	E. T. McCafferty, Mobile, Ala.	Theo. Middleton, Mobile, Ala.	

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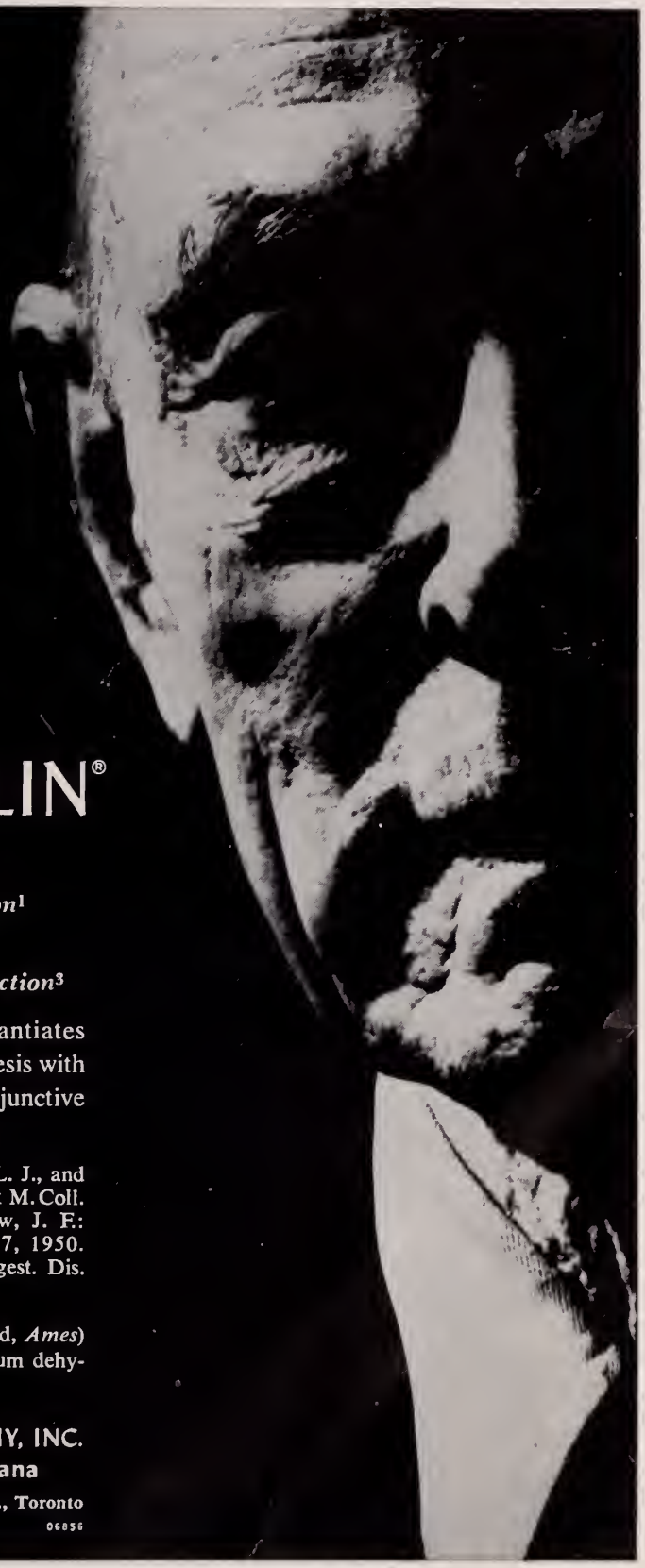
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County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Total Members
Alachua	Albert G. Love Jr., Gainesville	G. Leonard Emmel, Gainesville	2nd Tues.	53
***Bradford, Gilchrist, Union**				
Bay	Joseph H. Morris, Panama City	John J. Hollomon Jr., Panama City	1st Tues.	27
Brevard	Isabel Roberts, Melbourne	Jack T. Bechtel, Eau Gallie	2nd Tues.	35
Broward	Thomas F. Huey Jr., Fort Lauderdale	Anthony C. Galluccio, Hollywood	4th Tues.	121
Columbia	Thomas H. Bates, Lake City	Clifton G. York, Lake City	1st Mon.	11
***Baker**				
Dade	Hunter B. Rogers, Miami	Vincent P. Corso, Miami	1st Tues.	721
DeSoto-Hardee-Highlands-Glades	Merle C. Kayton, Wauchula	Roland W. Banks, Wauchula	1st Tues.	28
Duval	Joseph J. Lowenthal, Jacksonville	Charles F. McCrory, Jacksonville	1st Tues.	298
***Clay**				
Escambia	Gretchen V. Squires, Pensacola	Pascal G. Batson Jr., Pensacola	2nd Tues.	105
***Santa Rosa**				
Franklin-Gulf	Harold B. Canning, Wewahitchka	Photis J. Nichols, Apalachicola	Last Wed.	6
Hillsborough	James N. Patterson, Tampa	James A. Winslow Jr., Tampa	1st Tues.	196
Indian River	Vernon L. Fromang, Vero Beach	Enoch J. Vann Jr., Vero Beach	2nd Tues.	8
Jackson-Calhoun	Richard H. Schulz, Marianna	Francis M. Watson, Marianna	Quarterly	16
Lake	Geoffrey H. Binneveld, Leesburg	J. Basil Hall, Tavares	1st Wed.	25
***Sumter**				
Lee-Charlotte-Collier-Hendry	Joseph L. Selden Jr., Fort Myers	George D. Hopkins II, Fort Myers	3rd Mon.	37
Leon-Gadsden-Liberty-Wakulla-Jefferson	Robert H. Mickler, Tallahassee	Odis G. Kendrick Jr., Tallahassee	Quarterly	63
Madison	Candler K. Hayes, Madison	Wilmer J. Coggins, Madison		8
Manatee	Richard V. Meaney, Bradenton	Eugene E. Biel, Bradenton	2nd Tues.	29
Marion	William J. McGovern, Ocala	Robert L. Gibson, Ocala	3rd Tues.	30
***Levy**				
Monroe	Allen Shepard, Key West	William R. Ploss, Key West	1st Thurs.	14
Nassau	David G. Humphreys, Fernandina Bch.	John W. McClane, Fernandina Beach	Last Fri.	10
Orange	Thomas C. Butt, Orlando	W. Ansell Derrick, Orlando	3rd Wed.	184
***Osceola**				
Palm Beach	Walter R. Newbern, West Palm Beach	Horace D. Atkinson, West Palm Beach	4th Mon.	147
Pasco-Hernando-Citrus	Gail M. Osterhout, Inverness	W. Wardlaw Jones, Dade City	2nd Thurs.	17
Pinellas	Daniel F. H. Murphey, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	214
Polk	James T. Shelden, Lakeland	Marion W. Hester, Lakeland	2nd Wed.	95
Putnam	Bennie J. Massey, Palatka	Bernard E. Kane, Crescent City	2nd Tues.	9
St. Johns	Reuben J. Plant Jr., St. Augustine	Roy E. Campbell, St. Augustine	3rd Tues.	21
St. Lucie-Okeechobee-Martin	Alfred J. Cornille, Fort Pierce	Adrian M. Sample, Fort Pierce	3rd Thurs.	26
Sarasota	Eugene D. Liddy Jr., Sarasota	Karl R. Rolls, Sarasota	2nd Tues.	57
Seminole	William V. Roberts, Sanford	Terry Bird, Sanford	2nd Tues.	19
Suwannee	Shirley L. Hadden, Live Oak	Hiram B. Curry, Jasper	1st. Sat.	11
***Hamilton, Lafayette**				
Taylor	Ralph J. Greene, Perry	John H. Parker Jr., Perry	Last Fri.	5
				80
***Dixie**				
Volusia	Theodore F. Hahn Jr., DeLand	Achille A. Monaco, Daytona Beach	2nd Tues.	19
***Flagler**				
Walton-Okaloosa	Henry C. White Jr., Fort Walton Bch.	George W. Barrow Jr., Crestview	3rd Tues.	3
Washington-Holmes	Martin L. Lane, Chipley	L. H. Paul, Bonifay		
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(1) Schwimmer, D.; Boyd, L. J., and Rubin, S. H.: Bull. New York M. Coll. *16*:102, 1953. (2) Crenshaw, J. F.: Am. J. Digest. Dis. *17*:387, 1950. (3) King, J. C.: Am. J. Digest. Dis. *22*:102, 1955.

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Vol. XLII APRIL, 1956 No. 10

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IN THIS ISSUE

THE N.Y. ACADEMY OF MEDICINE
APR 10 1956
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Myasthenia Gravis
By a Doctor Who Has It

Euthyroid Hypometabolism
Carlos P. Lamar

Amebic Granuloma
Barkley Beidleman
and Joseph C. Wilson

Endocrinopathic Type of Vasomotor Rhinitis
Abraham R. Hollender

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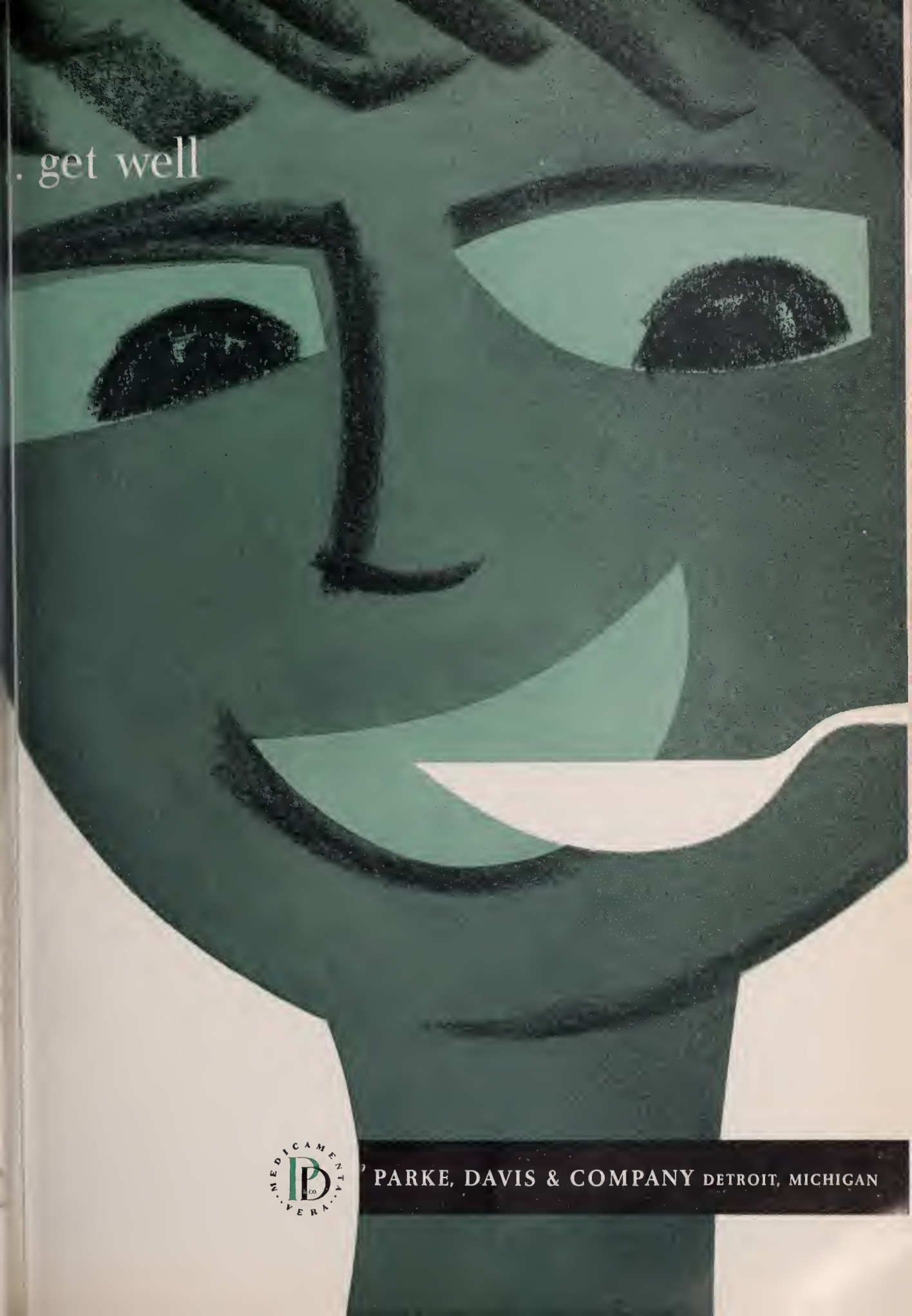
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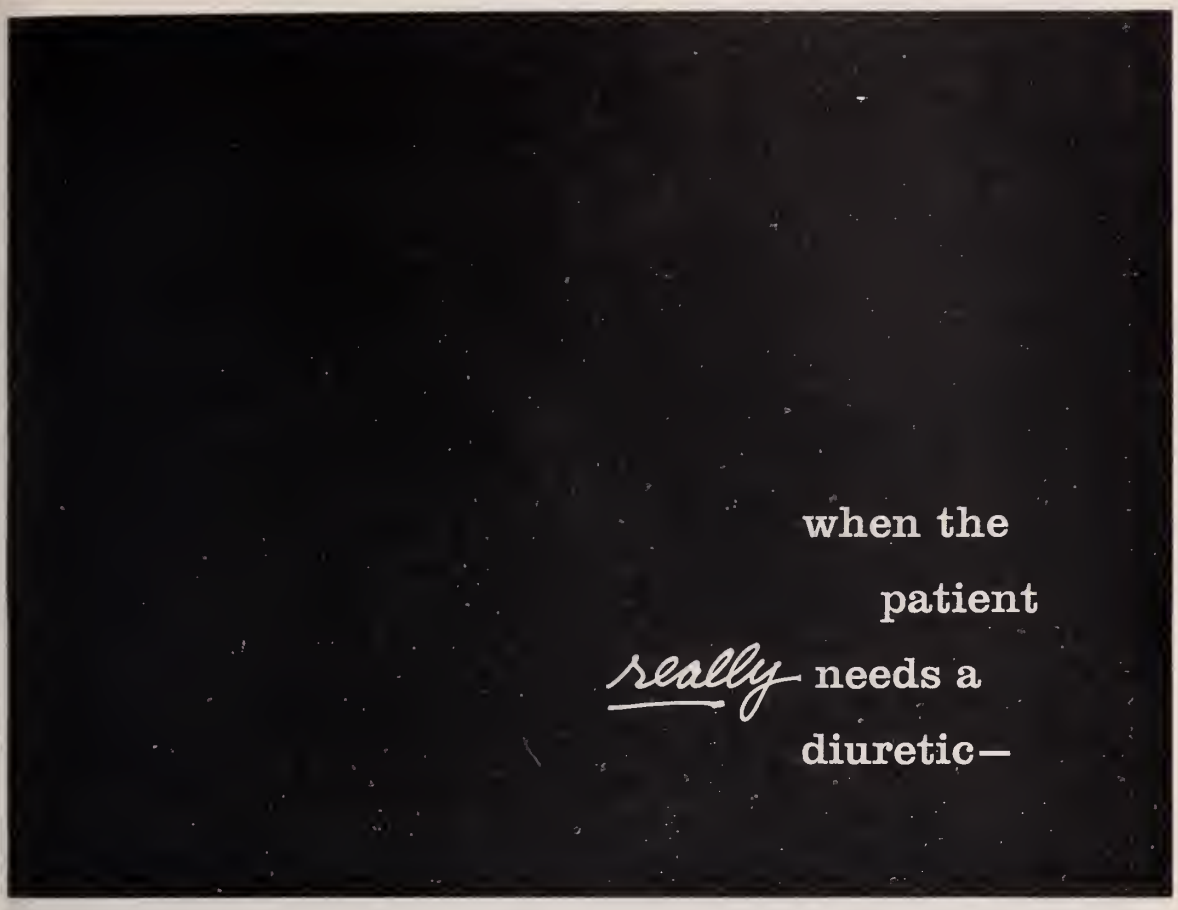
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1. Howell, T.H., et al.: Practitioner *173*:172 (Aug.) 1954.

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1. Grayzel, H. G., Heimer, C. B., and Grayzel, R. W.: New York St. J. M. 53:2233, 1953.
2. Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediatrics 68:382, 1951.
3. Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Ind. Med. & Surgery 18:512, 1949.
4. Turell, R.: New York St. J. M. 50:2282, 1950.

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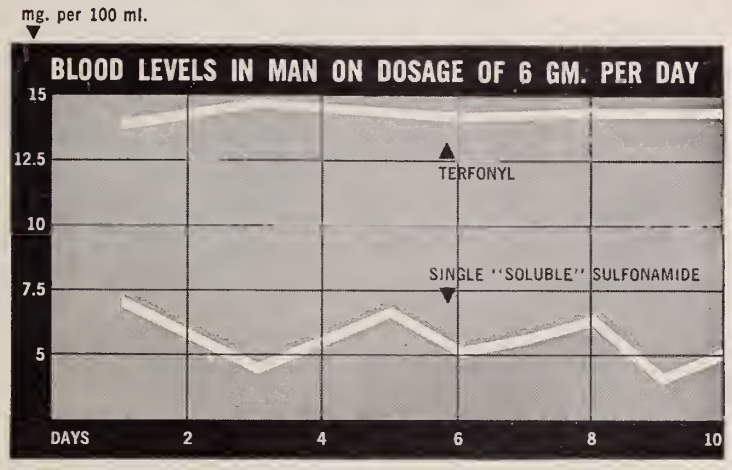
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(1) Payne, R. W.; Shetlar, M. R.; Farr, C. H.; Hellbaum, A. A., and Ishmael, W. K.: J. Lab. & Clin. Med. *45*:331, 1955. (2) Bunim, J. J.; Willioms, R. R., and Black, R. L.: J. Chron. Dis. *1*:168, 1955. (3) Holbrook, W. P.: M. Clin. North America *39*:405, 1955.

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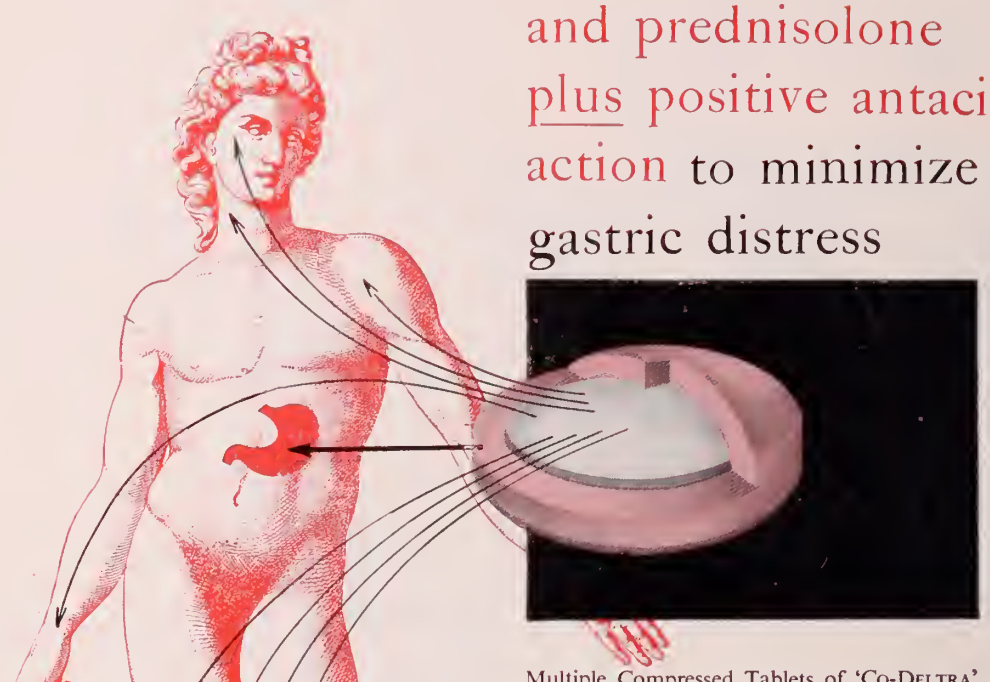


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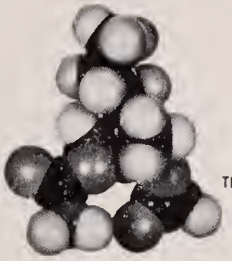
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Myasthenia Gravis

By A Doctor Who Has It

My favorite sports writer is Paul Gallico. He has been building himself up in me for 20 years. Once, in a witty article, Gallico asked, "What is it like to be on the floor from a punch with nine seconds to rise? What thoughts pass through a man's head when he has molasses in his legs? How can I write about these things graphically and understandingly without having experienced them? . . . There is no substitute for experience."

I know well what it is like "to be on the floor from" myasthenia gravis. I know "what thoughts pass through a man's head when he has molasses in his legs." In a 10 year fight with the disease I have learned its progress year by year. In early years I fell slowly and never hurt myself; in middle years suddenly and did hurt myself; in these latest two years I hurt myself both before and after falling. When a person has been increasingly paralyzed for many years, his bones may crumble and break of themselves, spontaneously. And then, O what pain. Within six weeks the acuteness of pain with accompanying muscle spasms subsides. The area around the affected bone remains sensitive while another bone may begin to crumble.

Diagnosis

The name myasthenia gravis comes from Greek words meaning muscular weakness which is grave or serious. Sometimes it is called pseudoparalysis or false paralysis because the excessive tiring of muscles may temporarily improve after rest. Exercising the affected muscles makes the disease worse. Myasthenia gravis may attack either sex at any age. At first it may affect one part more than another. Quickly or slowly it advances, paralyzing the whole body. But it is not inherited. And it is not contagious. In its first stages it can be a copycat of many diseases. In later stages individual cases may vary from one another. Figures 1 and 2 indicate the contrast between parallel groups of normal muscles and muscles affected by the disease.

So for many reasons this disease is difficult to diagnose. It was long thought rare until studies made during the past 10 years show it quite the opposite. These studies have given us both surgical procedures and a number of medicines relieving it. The average length of life after it has been diagnosed has been calculated as 10 years. Not only do many patients live longer, but also remissions may occur and have been known to last as long as 40 years before the disease struck again.

Personally, I was well until my senior year in high school. Then I was sick for three years. Doctors did not agree upon a diagnosis. But recent discoveries in myasthenia gravis suggest that that may have been what I had. If so, I enjoyed a 40 year remission. My plan to study medicine antedated the sickness. I returned to high school, entered college, medical college and practice.

After many years had passed, I became conscious of failing health. Although then I could still work, I knew that there was something wrong. But I could not say what. And as I could not, I have no blame for others.

Twice my trouble was called psychoneurosis. Twice it was called thyroid trouble, and then twice called myasthenia gravis. The first physician to say that I had myasthenia warned me not to reveal it unless verified by a second to whom, without revealing it, he sent me. I was then in San Francisco attending the 1946 Annual Session of the American Medical Association.



Fig. 1. — Albrecht Durer's Praying Hands. Photograph from a copy presented to the doctor in London in World War I.

Those two doctors told me that more advanced work on myasthenia gravis was being done elsewhere, mentioning New York and Baltimore. I went and was told that I did not have myasthenia but a very small heart. Soon the neurologist who remained in charge told me that I did have myasthenia; and six years later his dissenting consultant agreed with him. Those varying opinions clearly show the difficulties in diagnosing this disease. But now, fewer patients are called psychoneurotic when in the preclinical stage of disease, and diagnostic methods for myasthenia gravis are improved.

Adjustments

That summer of 1946 when told that I had myasthenia, I could not believe it. Dr. Osler had taught that myasthenia gravis was so rare that I might never *see* it. To *have* it was impossible, unthinkable, incomprehensible.

Nevertheless, following the years of my consciousness of failing health, for the whole of the past year I had become incapable of doing a full day's work and had been hospitalized for rest repeatedly. In each year I became a little more paralyzed; in each if I spoke or whispered, a little more apt to have to sit down, lie down or fall down. So, no matter what the diagnosis, the problem of how to make an adjustment had to be solved. Like other patients, I began to discover many things which could be done, at first on the bed and later in bed: among them I could write for my nephews and nieces a history of our families since their coming to Massachusetts in 1630; and I could select for medical men such items from current journals as might contribute to their specialties and research problems.

So time has gone at 75 miles per hour, and I cannot believe that I have been sick 10 years. Friends call this attitude "bravery or courage." I cannot agree. I believe the attitude comes from having absorbing intellectual interests. While I can work in bed, sickness is forgotten. When myasthenia so completely paralyzes that it stops me, I plan my next steps of work. Each patient will make his own adjustment by discovering what work he most enjoys doing, reminding him of the invalid, Elizabeth Barrett Browning, who wrote:

> "Dear work, if thou art the
> curse of God!
> What must his blessing be?"

Incapacitated in 1945, my disease first correctly diagnosed in 1946, I had weakness but no distressing attacks until 1950, when years of subacute pharyngitis, recurring after efforts to talk, and of painless lameness were becoming paralyses of vocal cords and of legs. Then like most patients, I refused to acknowledge distress, believing that I could and ought to bear it. I was personally ignorant of my moral weakness and incompetence, to be discovered later to my great mortification. And by that time I had become incapable of telling those most concerned what caused it.



Fig. 2. — Wrist drop, occurring in some patients with myasthenia gravis.

When the cat puts on a burst of speed chasing her tail in my room, I laugh. For the cat calls for no hurry on my part; so I am immune against her suggestion. But when a person hurries into the room, speaks in hurried, loud voice, I am susceptible to his suggestion. Instantly I try to cooperate. I try to answer quickly, try to whisper louder with paralyzed vocal cords or to reach paper and pencil to write an answer, knowing that he must hurry. And immediately I may lose control over the whole body, fall in extreme myasthenia incapable of cooperating and most uncomfortable.

If I could avoid exposure to every sudden thing with which I should cooperate, I could avoid many bitterest experiences of this disease. It is the cooperating which throws the patient into the agony and panic of extreme attacks. "Start" or startle has never been a problem to me, and noise as such means nothing so long as I know that I am not expected to cooperate. But speed is essential to the busy, rich, productive lives of those caring for the sick. And when they have left the room, they have no idea of the misery in which they have left the patient whose breath and strength have gone. Moreover, how could a nurse or doctor walk slowly, sit down before speaking, ask questions slowly?

Emotional outbursts usually have a background. My outburst came and mortified me in 1954, after experiencing four admissions to a hospital during as many years of increasing myasthenia.

With the voice becoming involved the cooperation of a patient during history taking strains him. Strain might be reduced by dividing the time into two or more shorter periods. Myasthenia gravis patients often have double vision. Four interns suddenly entered my room. They had eight heads, but no idea of the weakness I felt coming on as the last one walked out, nor of why I whispered in failing voice, "A hospital is a hell of a place to bring a patient with myasthenia."

"A furious man cannot be justified." I repented in sackcloth and ashes, but while

"Boys flying kites, take in their
white winged birds;
You can't do that when you're
flying words."

I am a doctor. Slowness looks impossible to me. I am a patient. I see that if there could be slowness and less talking, the strain on patients could be minimized. And those like myself (patients differ) could retain more strength and escape some falls into complete collapse.

The extremity of my distress may result from the following: Because atropine *in*creased the heart rate, I could never obtain its benefit to *de*crease the unfavorable side effects of Prostigmin Bromide, Mestinon, et cetera. After six years, the side effects of these drugs, in doses which relieved me, became so severe that since 1952 I have had to be without medication.

In 1955 I became unable even to whisper unless supine. Speech is a *re*flex. If you speak, I will naturally try to *re*spond, being self confident that I can at least whisper a few words. But then paralysis may increase, and I become incapable of both whispering and writing. "There is no substitute for experience." It teaches how a man feels when unable to move, incapable of lifting head or finger, unable to swallow, choking, barely able to breathe, his whole body nothing but a conscious misery.

Patients wonder whether I am ever depressed. Yes. Sometimes. But I have two doctors, human and divine. The one, good, helpful, indulgent with all my foibles. The other, the Great Physician of body, mind and spirit, physician, psychiatrist, minister, three in one. As we become sick we are not helpless ships without harbor light, without harbor, without anchor. Giving thanks daily for what helps, comforts, advantages we enjoy, is worth while. For example, although myasthenia weakens the body it does not weaken the mind. Giving thanks drains off irritation, bitterness, madness at my weakness. And it maintains contact with the First Force commonly called Nature or God. A courageous acceptance of life goes far beyond mere resignation.

The elastic of life stretches at both ends. There is no one of us who has not made a million adjustments from his infancy or who will not continue making adjustments through life. Where a well person may not believe what I write, he might come to believe if he had years of sickness. How? By his own discovery. Like Byrd exploring at the South Pole. And then he would laugh at the surprises of his own life. The amazement of it. As in all exploration, not only is there hardship, there is also thrill, satisfaction, joy and even occasional fun; whether at the pole or elsewhere, he discovers the unknown, including the unknown within him. In time of need he may be transformed by the renewing of his mind.

That this renewing occurs under pressure of difficulties shows it parallel to exploration. So I have discovered more than in 30 years as physician and professor in two universities. My discovery is not new poles. It is new experiences. A new mind, new eyes, a new look at life. There is nothing unusual about a doctor. If he can adjust to myasthenia gravis, anybody can, or to like disease if he have to. Probably he will never have to.

Scientific Approach

By contributing all I can and receiving the reports on research, I am in a position to appreciate what a difference there is between having a disease and having a scientific approach to a disease.

As soon as the cause and cure of myasthenia gravis have been discovered, the foundation organized for the purpose in 1952 will be dissolved. Its lay officers are persons having relatives with the disease. So among other activities, they can initiate constructive friendships between patients so desiring. Its medical officers are specialists having patients under their care. Its address is, Myasthenia Gravis Foundation, Incorporated, New York Academy of Medicine Building, 2 East 103rd St., New York 29, N. Y. Its branches spread across the States and into Canada.

In December 1954, the Myasthenia Gravis Foundation held an International Medical Conference. An 85 page Symposium of the proceeding appears in the American Journal of Medicine, November 1955.

Summary

A doctor who has myasthenia gravis writes in a popular vein: first, to encourage patients, tell what the disease is and what it is not, why hard to diagnose, possibilities of adjusting and of their finding friends through the Myasthenia Gravis Foundation, the address of which is given; secondly, to inform doctors of experiences not seen reported in the literature (chronologically, the first and second fuse); and finally, to refer to the Symposium on Myasthenia Gravis.

Euthyroid Hypometabolism

CARLOS P. LAMAR, M.D
MIAMI

After its standardization by DuBois[1] and up to the recent development of more specific diagnostic procedures, the determination of the basal metabolic rate ("indirect calorimetry") has been relied upon almost universally for the diagnosis of thyroid disease. It is true that, in most cases, the most important single variable affecting the basal metabolic rate is the level of thyroid function. There are many other factors, however, which may and do affect the basal metabolic rate. Thus Houssay and his associates[2] list at least 12 nonendocrine factors which have such effects: age, sex, race, altitude, psychic and emotional state, pregnancy, intercurrent diseases, and the administration of certain drugs.

A low basal metabolic rate only means that the consumption rate of oxygen by the chemical metabolic processes of life, involving hormones, enzymes, vitamins, and minerals, is proceeding at a slower rate than the physiologic standard. Thyroid hormone is but one of several endocrine factors involved in regulating such speed of oxygen consumption. Carbohydrate metabolism, which includes innumerable instances of oxygen exchanges and which is affected by many hormonal and enzymatic variants, can by itself, if deranged, alter the basal metabolic rate. Diabetic patients long have been known to exhibit a low basal metabolic rate without hypothyroidism; however, this does not exclude the occasional occurrence of both deficiency syndromes in the same person.

The relationships between basal metabolic rate, thyroid function and adrenal cortex activity are highly complex and not yet completely understood. It is known that the basal metabolic rate is apt to be decreased in Addison's disease, even in the face of a normal level of thyroid hormone as determined by the serum protein-bound iodine.[3]

From the Department of Medicine, Section of Endocrinology and Metabolism, and Diabetes Clinics, Jackson Memorial Hospital, University of Miami School of Medicine.

This would seem understandable on the basis of reduced gluconeogenesis and the maintenance of a low level carbohydrate metabolism due to the lack of glucocorticoids thus consuming lesser amounts of oxygen. On the other hand, the complexity of the problem has been emphasized by reports that the negative nitrogen balance induced by feeding thyroid in quantities sufficient to produce hyperthyroidism may be relieved by administration of adrenal cortex extracts.[4] Also, sublethal injury to the adrenal cortex may, under certain circumstances, be followed by an increase rather than a drop in the basal metabolic rate.[5]

Since more specific tests such as serum protein-bound iodine determinations and the measurement of I^{131} uptake by the thyroid gland have become available, comparisons with the basal metabolic rate have shown many instances of lack of correlation.[6,7]

Recently the serum protein-bound iodine determination has become sufficiently simplifed and precise to be available as a routine clinical laboratory procedure. It has been advocated as reflecting more accurately the level of thyroid gland function. This opinion is based on the fact that the thyroid hormone contains iodine chemically bound to the protein molecule. It is assumed that this hormonally active iodine represents a constant fraction of the total protein-bound iodine. While this is not entirely true in all cases, it seems to be reliable at first approximation. More accurate correlations between the level of thyroid function and the butanol-soluble fraction of organic iodine after alkaline hydrolysis would be expected, since the butanol-soluble fraction probably represents a more nearly pure fraction of hormonal iodine. In cases of thyroid disease, however, in which the basal metabolic rate is not significantly affected by nonthyroid factors, there seems to be a fairly good correlation between the basal metabolic rate and the level of the serum protein-bound iodine.[8-10]

With the increasing availability of still another method of appraising thyroid function, the radioactive iodine uptake, this relationship has been further explored. The rate of uptake of radioactive iodine by the thyroid gland measures the rate at which the thyroid gland is removing iodine from the circulation. An even more accurate index of thyroid function may be obtained if the amount of I^{131} excreted in the urine is taken into account.[11] Perhaps a still more accurate estimate may be obtained by measuring the PBI^{131} after administration of a tracer dose of radioactive iodine. In any event, with the basal metabolic rate, protein-bound iodine and the radioactive iodine uptake available as measures of the kinetics of the thyroid gland, a systematic investigation of the interrelationships between the thyroid and the adrenal cortex is possible.

In Addison's disease, basal metabolic rate may be depressed despite normal protein-bound iodine levels. Administration of excessive amounts of cortical steroids or ACTH, however, may induce a lowering of the basal metabolic rate due to decrease in thyroid function as measured by protein-bound iodine levels and I^{131} uptake as demonstrated by Wolfson and his associates.[12] Hill, Reiss, Forsham and Thorn[13] reported on their findings in some detail. Zingg and Perry[14] also reported that androgens may depress thyroid function and presumably also lower the basal metabolic rate, a finding which I can confirm in a preliminary way in my cases with inoperable carcinoma of the breast treated with large doses of androgens by pellet implantation.[15]

While the protein-bound iodine, the basal metabolic rate and I^{131} uptake are ordinarily closely correlated in normal persons and in those suffering from pure thyroid disorders, there are instances in which the correlation fails.[13,14] In such instances it is desirable to keep in mind the possibility that malnutrition, psychogenic factors, or adrenal cortical inadequacy is playing a role, since any one of these may lower the basal metabolic rate in the face of a normal protein-bound iodine and a normal I^{131} uptake.

As it has become a generally accepted practice to diagnose hypothyroidism and to prescribe thyroid medication — sometimes in really high doses — whenever a low basal metabolic rate is reported, I believe that it is worth pointing out that stages of adrenal cortical deficiency which fall short of the complete picture of Addison's disease, and psychogenic disorders which sometimes are accompanied by disturbances of carbohydrate metabolism, may depress the basal metabolic rate in the absence of thyroid deficiency. Failure of dessicated thyroid in relieving the patient's complaints in many such instances, and in some of them the production of obvious iatrogenically induced thyrotoxicosis, have lowered the specificity of the basal metabolic rate determination as a diagnostic test for hypothyroidism.

The present report deals with a few such cases taken from my private practice, which illustrate, I believe, the necessity for a more careful evaluation of each patient, before prescribing such a dangerous drug as thyroid, than that which is obtained simply from a reported low basal metabolic rate.

Report of Cases

Case 1. — Miss Z. W., aged 15, a high school student, was brought to me by her mother in July 1953, complaining of extreme fatigability, sleepiness, irritability, anorexia, loss in weight and numerous "allergies." The parents were of high social and intellectual level but also highly temperamental; there were constant conflicts and arguments at home. The physical findings were normal except for moderate underweight. The height was 68.0 inches, the weight 110.0 pounds, the pulse rate 74 per minute, and the blood pressure 125 systolic and 70 diastolic. The basal metabolic rate was minus 32 per cent. The serum cholesterol was 218 mg. per hundred cubic centimeters, and the serum protein-bound iodine was 5.0 gamma per hundred cubic centimeters.

DIAGNOSIS: Psychogenic hypometabolism associated with a mild form of anorexia nervosa, due to parental maladjustment.

TREATMENT: Psychotherapeutic readjustment. The parents were interviewed separately and informed of their etiologic responsibility in their daughter's disturbances. Multivitamins were prescribed mostly for their psychotherapeutic effects.

RESULTS: By October 1953 there was a complete clinical recovery with correction of all complaints and restoration of the basal metabolic rate to minus 8 per cent. The serum cholesterol was 187 mg. per hundred cubic centimeters and the serum protein-bound iodine 4.7 gamma per hundred cubic centimeters. Normalization of the basal metabolic rate was accomplished without thyroid medication.

Case 2. — Mrs. F. H., aged 37, was divorced after five years of her first marriage, with a 3 year old child, and had married again a year later. She consulted me in July 1953, complaining of extreme fatigability, sleepiness, intense irritability, periods of amenorrhea of three to five months' duration, craving for sweets, neurogenic bulimia, obesity and frequent episodes of highly pruriginous neurogenic dermatitis. This condition had been present for about two years, since her divorce. She had been under treatment elsewhere with a diagnosis of hypothyroidism because of repeated reports of a low basal metabolic rate. She had not been able to tolerate thyroid medication, which had induced tachycardia, palpitations, extrasystoles and intensification of nervousness and insomnia.

The divorce court had stipulated that the child would remain in the custody of the mother and charged the father with financial responsibility for his upkeep, with rights to visit him frequently. The father had kept up constant interference between the mother and child, producing a continuous state of tension.

The physical findings were normal except for moderate obesity and two areas of dry, scaly dermatosis at the anterointernal aspects of both ankles. The height was 64.0 inches, the weight 165.0 pounds, the pulse rate 78 per minute, and the blood pressure 130 systolic and 80 diastolic. The basal metabolic rate was minus 23 per cent, the serum cholesterol 208 mg. per hundred cubic centimeters, and the serum protein-bound iodine 4.1 gamma per hundred cubic centimeters. The oral glucose tolerance test was of the "flat" type usually associated with hypothyroidism. The blood sugar levels in milligrams per hundred cubic centimeters were as follows: fasting 90; at 30 minutes 94; at one hour 82; at two hours 85, and at three hours 88

DIAGNOSIS: Despite the low basal metabolic rate and "flat" glucose tolerance curve, the lack of physical signs of hypothyroidism, the previous intolerance to thyroid medication, and the normal levels of serum protein-bound iodine and cholesterol justified a diagnosis of psychogenic hypometabolism, bulimia and neurogenic dermatosis.

TREATMENT: Psychotherapeutic reassurance and adjustment. An attorney was consulted, and eventually a court injunction prevented the first husband from further interference between mother and child. A low caloric diet and also supplementary vitamins and anorexics were prescribed.

RESULTS: Six months later there was almost complete clinical recovery. The weight was 150.0 pounds, the basal metabolic rate minus 8 per cent, the serum cholesterol 190 mg. per hundred cubic centimeters, and the serum protein-bound iodine 4.5 gamma per hundred cubic centimeters. The hypometabolism was corrected without the use of thyroid medication.

Case 3. — Mr. J. R., aged 39, married with two children, was a high pressure business executive, overworked, overtensed, overweight, and a heavy drinker for years up to January 1952. At that time several carbuncles appeared at the back of his neck, and he began to suffer from progressive fatigability, polydipsia, polyuria, and polyphagia. The glucose tolerance test showed a typical diabetic curve. The weight was 195.0 pounds and the height 70.0 inches. The pulse rate was regular at 78 per minute, and the blood pressure was 110 systolic and 74 diastolic. Under intensive antibiotic therapy, abstention from alcohol and a well regulated diet the carbuncles and all symptoms and signs of diabetes mellitus disappeared within six weeks, except for persistent physical and mental fatigability. By April 1952 the fasting and postcibal glycemias were normal, and the weight had been reduced by dieting to 163 pounds. The blood pressure was 102 systolic and 80 diastolic, and he felt markedly weak and tired, expressing thoughts of depression and loss of self confidence. A thorough check-up was carried out, and the basal metabolic rate was minus 21 per cent, the serum cholesterol 254 mg. per hundred cubic centimeters, and the serum protein-bound iodine 4.7 gamma per hundred cubic centimeters. The circulating eosinophil count was 211 cells per cubic millimeter, and it fell only to 185 cells four hours after the injection of 25.0 mg. of ACTH. A vacation was prescribed with sufficient rest away from the pressure of business, along with dessicated thyroid, 0.5 grain daily, oral multivitamins, and injections of lipoadrenal extract.

He returned a month later still depressed and tired. The weight was 164.0 pounds, the blood pressure 108 systolic and 76 diastolic, the basal metabolic rate minus 27 per cent, the serum cholesterol 268 mg. per hundred cubic centimeters, and the serum protein-bound iodine 4.1 gamma per hundred cubic centimeters. The circulating eosinophil counts were 275 cells per cubic millimeter before and 171 cells four hours after the ACTH injection. Twenty-four hours later the count had reverted to 256 cells.

DIAGNOSIS: It seemed evident by this time that thyroid administration had further depressed rather than improved the state of hypometabolism. At the same time, the injections of lipoadrenal extract had been insufficient to correct the hypoadrenia present. A diagnosis of hypometabolism due to chronic hypoadrenia was then established.

TREATMENT: On the assumption that the hypoadrenia might become corrected after a period of stimulation with corticotropin, treatment was started with daily injections of a long-acting form of this hormone (HP* ACTHAR Gel) in initial doses of 40.0 mg., which gradually were reduced to 20.0 mg. daily.

RESULTS AND FOLLOW-UP: A remarkably rapid and intense subjective and objective improvement took place and has persisted up to the time of this writing in May 1955.

By December 1952 the weight was 168.0 pounds, the blood pressure 130 systolic and 80 diastolic, the basal metabolic rate minus 10 per cent, the serum cholesterol 175 mg. per hundred cubic centimeters, and the serum protein-bound iodine 5.5 gamma per hundred cubic centimeters. The postcibal glycemia was 100.0 mg. per hundred cubic centimeters. The eosinophil counts were respectively 219 and 150 cells per cubic millimeter before and four hours after the injection of 25.0 mg. of ACTH. These findings were interpreted as indicating a permanent state of hypoadrenia with inability to improve lastingly by ACTH stimulation of the defective adrenals. Oral replacement therapy with cortisone acetate being more convenient than the daily injections of corticotropin, the patient has been receiving an oral maintenance dose of 37.5 mg. daily since December 1952. With the exception of an abscess of the left forearm resulting from an infected small wound, which healed promptly under antibiotics, he has not had a single day's illness and has returned to his highly successful and extremely intense business activities, claiming at his — at present — semiannual check-ups that now he never feels tired.

Case 4. — Mrs. D. R., aged 24, a housewife with two children, well developed and slender, complained in January 1952 of progressive hypoacusia along with intense fatigability, anorexia, frigidity, irritability and mental depression. She had been asthmatic from childhood, with frequent episodes of severe dyspnea of several days duration following frequent infections of the upper part of the respiratory tract. There were scattered areas of paresthesias and neuritis as well as continued loss in weight and "craving for sweets" despite the anorexia.

The stature was 62.75 inches and the weight 107.0 pounds. The blood pressure was 100 systolic and 65 diastolic, and the pulse rate 76 per minute with no other significant physical findings. The basal metabolic rate was minus 20 per cent, the serum cholesterol 210 mg. per hundred cubic centimeters, and the serum protein-bound iodine 5.8 gamma per hundred cubic centimeters. The Thorn test exhibited deficient eosinopenic response to ACTH stimulation of the adrenal cortex with the following counts of circulating eosinophils: 648 cells per cubic millimeter before the injection of ACTH and 560 and 528 cells respectively four and 24 hours later.

DIAGNOSIS: Hypometabolism, with associated allergic manifestations, due to hypoadrenia.

TREATMENT: An attempt was made at stimulating better adrenal-cortical function through daily injections of long-acting corticotropin gel. Excellent remission of all symptoms occurred immediately and has been maintained ever since, but repeated tests have shown a lack of improvement in the poor eosinopenic response of the adrenals to ACTH. This was interpreted as due to permanent adrenocortical damage, and she was given replacement therapy with oral cortisone acetate in April 1953 and hydrocortisone acetate in October of the same year.

RESULTS: She has remained in excellent health as long as the levels of circulating eosinophils have been kept below 150 cells per cubic millimeter. The replacement dose, initially much higher, has been only 5 to 10 mg. of the hormone twice daily for the last year. The weight stays around 120 pounds and the blood pressure at 120 systolic and 80 diastolic. The asthma has not returned, and, incidentally, the hypoacusia was arrested and the hearing has returned to normal.

Case 5. — Mr. A. R., aged 30, a charter boat operator, was the husband of the patient described in case 4. In January 1953, when her disease had been in satisfactory remission for about one year, she brought him to consult me because he had been experiencing progressive feelings of exhaustion with pronounced anorexia and a loss in weight of 20 pounds in the last year. He also complained of severe leg cramps and loss of libido and potency, which had led him to heavy drinking. It was peculiar that he also experienced a craving for sweets, which is rather unusual in alcoholics.

The stature was 69.0 inches, and the weight 146 pounds. The blood pressure was 120 systolic and 80 diastolic, and the pulse rate 70 per minute. There were no significant physical findings, and the prostate gland, which appeared "boggy" and tender at first examination, was found normal a few weeks later. The basal metabolic rate was minus 27 per cent, the serum cholesterol 264 mg. per hundred cubic centimeters, and the serum protein-bound iodine 5.6 gamma per hundred cubic centimeters. The oral glucose tolerance curve showed a fasting glycemia of 100 mg. per hundred cubic centimeters and 136, 108, 104 and 65 mg. respectively at 30 minutes, one, two and three hours after ingestion of 100 Gm. of dextrose in solution. Circulating eosinophil counts were 612 cells per cubic millimeter before and 562 four hours after injection of 25.0 mg. of ACTH.

DIAGNOSIS: Hypoadrenic hypometabolism inducing secondary impotence and alcoholism.

TREATMENT: Cortisone acetate orally in three daily doses totalling up to 225 mg. a day was required for several weeks before complete remission was obtained and sustained. Although these relatively high doses were kept up for about two months, at no time was any edema or other manifestations of overdosage detectable. In October 1953 the maintenance dose was adjusted to 20 mg. of hydrocortisone acetate orally every eight hours. Later the dose was gradually reduced further and for the past year it has been 10 to 15 mg. per day. The levels of circulating eosinophil counts have been used to regulate the dose in the same fashion as described in the case of his wife.

RESULTS: He has recovered his sexual powers as well as his physical stamina and well-being and has been able to return to the moderate or "social" type of consumption of alcoholic beverages without need for complete abstention, as he now feels so well that he only drinks for pleasure, while before apparently he used to drink in excess in order to dull his pains and worries.

Case 6. — Mrs. E. S., aged 69, a widow, had a thyroidectomy for exophthalmic goiter about 20 years ago. Since that time she had been taking dessicated thyroid in a dose of 0.5 grain daily almost continuously all through the years. Soon after the operation she began suffering from progressively increasing fatigability, irritability and mental depression along with anorexia, numerous paresthesias, neuralgias and arthritis of various joints. There was an exaggerated intolerance to cold and dampness and, despite the reported anorexia, a considerable degree of obesity. These complaints were attributed to hypothyroidism elsewhere, and numerous attempts were made to increase the dose of dessicated thyroid above 0.5 grain daily. Each attempt to increase this dose was followed by an intensification of the complaints with the addition of tachycardia and palpitations.

Physical examination in March 1952 disclosed an obese woman looking older than her stated age, extremely irritable and suspicious, constantly complaining and obviously emotionally unstable. The height was 63.0 inches, weight 164.0 pounds, pulse rate 86 per minute, and blood pressure 130 systolic and 80 diastolic. The basal metabolic rate was minus 21 per cent and minus 25 per cent, the serum cholesterol 250 mg. per hundred cubic centimeters, and the serum protein-bound iodine 5.5 gamma per hundred cubic centimeters. Fasting counts of circulating eosinophils ranged from 218 to 377. The Thorn test for eosinopenic response to ACTH showed an initial count of circulating eosinophils of 296 cells per cubic millimeter. Following the injection of 25.0 mg. of ACTH the counts were 205 in four hours and 316 in 24 hours.

DIAGNOSIS: Hypometabolism due to chronic hypoadrenia complicating a mild post thyroidectomy hypothyroidism.

TREATMENT: Cortisone acetate orally. Doses as high as 200.0 mg. per day were required in the initial stages for adequate therapeutic response. Thyroid replacement was kept at 0.5 grain daily.

RESULTS: There was immediate subjective improvement, and the dose of cortisone was gradually reduced to 37.5 mg. per day by May 1953. At that time she

reported definite increase in strength for the first time in years, had a good appetite and "ambition to move," and was sleeping well. She was sufficiently recovered to return to her home in a midwestern city. She was referred to a competent internist, who, after reviewing the data and at first not accepting my diagnosis, tried to discontinue the cortisone replacement and increase the dose of thyroid instead. The results were so intense that cortisone therapy was promptly replaced. This patient returned to Miami for a visit in April 1954 and came to express her gratitude. All my office personnel was remarkably impressed with the enormous change which had taken place in her attitude. A previously choleric and unreasonably demanding person, she returned as a sweet, courteous, grateful and most pleasant lady. She was still taking 37.5 mg. of cortisone acetate orally in three daily divided doses along with only 0.5 grain of dessicated thyroid daily.

Summary and Conclusions

Two cases of hypometabolism associated with emotional disturbances and 3 associated with adrenal cortex deficiency are presented. In all 5 there were normal levels of serum protein-bound iodine concentration in the presence of low basal metabolic rates, and in all the deficiency was corrected without the use of thyroid medication. A sixth case is reported in which post thyroidectomy mild hypothyroidism was severely complicated by hypoadrenia. There was no response to increases in thyroid replacement, but adequate adrenal steroid replacement therapy proved highly effective.

Since the determination of protein-bound iodine levels in blood serum has become fairly well available in an increasing number of clinical laboratories, any low basal metabolic rate which is not associated with frank signs and symptoms of hypothyroidism should at least be "checked" by a serum protein-bound iodine test before thyroid medication is prescribed. The indiscriminate administration of such a potent drug as dessicated thyroid to every patient exhibiting a low basal metabolic rate may result in aggravation of the patient's symptoms and in the development of iatrogenic toxic hyperthyroidism.

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BLUE SHIELD ANNUAL MEETING

The Eleventh Annual Meeting of Blue Shield of Florida is being held Sunday, May 13, beginning at 8:00 p.m., in the North Card Room of the Hotel Fontainebleau. Preceding the annual meeting, the Board of Directors will meet at 5:00 p.m. in the Board Room of the same hotel.

Amebic Granuloma

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and
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Fort Walton Beach

Formation of a granulomatous mass in the wall of the colon is reportedly an unusual complication of infection with Endamoeba histolytica. An excellent review of the subject, including a bibliography, has recently appeared elsewhere.[1]

We wish to report 2 additional cases and to draw particular attention to several aspects of this problem.

Report of Cases

Case 1. — A 28 year old married white male service-station operator was followed from Jan. 6 to April 27, 1953, for various complaints associated with a chronic moderate anxiety reaction dating from army combat experiences from 1943 to 1945. These symptoms included two to three normal formed stools daily.

During the week prior to May 6, 1953, there were frequent loose stools containing blood and pus, with cramping pain in the right upper quadrant of the abdomen. Four purged stools contained many erythrocytes and leukocytes, as well as trophozoites and cysts of E. histolytica. Barium enema (fig. 1) revealed a granulomatous mass in the transverse colon just distal to the hepatic flexure. He received 60 mg. of fumagillin daily for three days. Nausea, vomiting, and increasing diarrhea necessitated reducing the dose to 30 mg. per day for 22 additional days. No further side effects were noted. The diarrhea ceased and the original symptoms subsided during the first week on the reduced dosage. Through a misunderstanding, no immediate post-therapy studies were performed.

He remained asymptomatic. Three purged stools on Feb. 13, 1954, nine months later, gave negative evidence. A barium enema (fig. 2), the same day, showed no abnormalities.

The patient returned in March 1955, with a history of diarrhea of several weeks' duration. Stools again contained E. histolytica. A barium enema showed some irregularity of the mucosal pattern of the cecum, but the area formerly occupied by the granuloma remained normal. Treatment with emetine, chloroquine, Diodoquin and Milibis again eradicated the amebas from the stools. No further roentgenograms have been taken.

This episode was regarded as a reinfection, although a flare-up from an asymptomatic carrier state obviously cannot be completely ruled out.

Case 2. — A 50 year old married white male machinist, with a past history of a posterior gastrojejunostomy for chronic duodenal ulcer in 1946, was first seen on Oct. 5, 1954. For the preceding five months, he had had three to 15 loose stools daily, occasionally containing both dark and bright red blood. Except for occasional mild rectal tenesmus, he denied other gastrointestinal and constitutional symptoms.

Physical examination revealed no pertinent abnormalities. Sigmoidoscopy to 20 cm. showed only several tiny "bleeding points." An aspiration specimen of one of these contained no amebas. A barium enema (fig. 3) revealed an extensive irregular filling defect of the cecum and the ascending colon just above the ileocecal valve. Microscopic examination of a single unpurged diarrheal stool showed many erythrocytes, mucus, and many cysts and active trophozoites typical of E. histolytica.

The patient had taken 2.5 Gm. of Aureomycin over a two and one-half day period. This was followed by fumagillin, 60 mg. daily in divided doses, for 10 days. By the end of that time, the diarrhea had ceased, but stools were still positive for E. histolytica, and a barium enema showed no change in the lesion. He then received chloroquine, 1.0 Gm. daily for two days, followed by 0.5 Gm. daily for 10 days. During this same time, he took Diodoquin, 1.95 Gm. daily, extended to a total of 20 days. At that time, three purged stools contained no amebas and a barium enema (fig. 4) indicated definite diminution in the size and extent of the original lesion.

Two days before stopping the Diodoquin, the patient started Milibis, 1.5 Gm. daily for eight days. Four days after cessation of all therapy, purged stools gave negative evidence, and barium enema showed complete disappearance of the granuloma. Stool and barium enema (fig. 5) examinations gave negative results three months thereafter.

Comment

Emphasis should be placed on three facets:

First, in any patient with a filling defect of



Fig. 1. — (Case 1) Barium enema before treatment. Arrow indicates area of involvement by amebic granuloma. No roentgenogram showing barium present in the considerably narrowed lumen at the point of involvement was obtained, although it was well visualized fluoroscopically.

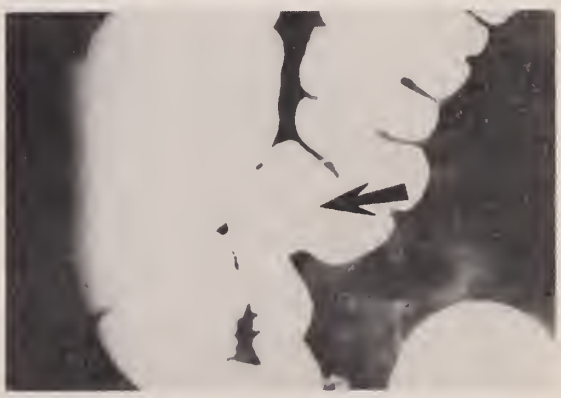


Fig. 2. — (Case 2) Barium enema after treatment. Arrow indicates area formerly involved by amebic granuloma.



Fig. 3.—(Case 2) Barium enema before treatment. Upper arrow identifies the granuloma. Lower arrow indicates coincident amebic typhlitis.



Fig. 4.—(Case 2) During therapy. Note improvement.



Fig. 5.—(Case 2) After treatment. Normal cecum and ascending colon.

the colon on barium enema, amebic granuloma must be included in the differential diagnosis. This must be particularly so in Florida and the southeastern United States, where amebas are ubiquitous.

Second, as occurred in each of the 2 cases presented here, the initial impression may be that of carcinoma of the colon. The identification of E. histolytica in the stools does not necessarily change this impression, but does make a therapeutic trial of antiamebic drugs mandatory. Adequate therapy of this sort will produce detectable regression of the granuloma within two to four weeks, thereby avoiding operative attack upon the lesion. Transperitoneal biopsy and/or resection carry an almost prohibitive mortality in patients whose suspected carcinoma is actually an amebic granuloma.

Third, fumagillin (Fumidil, Abbott) was effective in one of the 2 cases reported here. With a newer, more stable form now available, this drug probably deserves additional trial, contrary to previously expressed opinion.[1]

We are indebted to Dr. Nathan Arenson for performing the roentgen examinations, to Dr. George W. Morse for referring case 2, to Mr. Charles Glagola for the photographic reproductions, and to Mrs. Nell Boyette for the laboratory examinations.

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Studies in the Endocrinopathic Type of Vasomotor Rhinitis:

Preliminary Report

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Failure to recognize the existence of an endocrinopathic type of vasomotor rhinitis probably accounts for the unsuccessful results in many patients with conventional allergic methods. The allergist has correctly assumed that nasal allergy is a definite clinical entity. That vasomotor rhinitis does not necessarily fall in this category has not, however, been adequately considered. The question for decision is whether the etiology, the symptoms, or the histology should be the governing factor in determining the nature of the disease.

Brunner[1] maintained that the diagnosis of vasomotor rhinitis is based on its symptomatology, whereas the diagnosis of allergic rhinitis is based on its etiology. He contended that allergic rhinitis is invariably a vasomotor rhinitis, but that the latter is not invariably due to allergy. That there may be other etiologic factors — mechanical, psychic or endocrine, is well recognized and supported by experience. This study is concerned mainly with the role of the endocrines in vasomotor rhinitis. Though emphasis is placed on measurement of thyroid activity, it should not be assumed that the potential role of the other ductless glands has not been considered.

It should also be noted that cognizance has been taken of thyroid-adrenocortical interrelations and of other aspects, such as the precipitating factors in allergic disease. Obviously, discussion of these several phases must remain for future undertakings. In this preliminary report, only material referable to the title will be included.

Background

In 1921, Novak[2] reported that the basal metabolic rate is frequently on the minus side in hyperesthetic rhinitis. In 1923, Novak and I[3] theorized that the calcium content of the blood serum bore some relationship to nasal allergy. This investigation carried us far afield, especially as it concerned the therapeutic aspect. Though the calcium concept had to do with the parathyroids, inability to obtain a good product led us to utilize thyroid extract. With it we found that the symptoms of sneezing and rhinorrhea could be relieved in patients with so-called hyperesthetic rhinitis if the basal metabolic rate was on the minus side.

In 1927, Novak,[4] in his enthusiasm, associated hyperesthetic rhinitis and myxedema. While I have never completely shared the view that rhinitis should be included in the myxedema syndrome, I have always been convinced that the endocrines as a factor in vasomotor rhinitis could not be ignored. From time to time, I[5] have called attention to this relationship. In their book, Allergy in Practice, published in 1946, Feinberg, Durham and Dragstedt[6] stated: "One cannot escape the impression that endocrine function plays a role in hyperesthetic rhinitis (as well as other allergic conditions)." Urbach and Gottlieb,[7] likewise, maintained that menstruation, the menopause and ovarian dysfunctions are factors tending to enhance existing states of allergy.

In 1945, Laub[8] reported on rhinitis vasomotoria due to imbalance of the endocrine glands. In a comprehensive article dealing with vasomotor rhinitis, Walsh,[9] in 1950, expressed the view that a sympathetic-parasympathetic imbalance was responsible for the nasal state, and that endocrine dysfunction was one of the factors leading to such an imbalance.

Reilly,[10] in 1953, called attention to hypothyroidism in pediatric allergy. An interesting report on the changes in the organs of the upper part of the respiratory tract in hypothyroidism was presented by Laskiewicz.[11] This worker used the term hypothyreosis and listed the nasal symptoms incident to such a state.

Proetz, [12,13] in 1947, and again in 1950, described the effect of thyroid deficiency on the nasal mucosa and reported favorable results with thyroid therapy. In 1951,[14] I reviewed the sub-

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ject of thyroid dysfunction in relation to rhinologic disease and determined then to reinvestigate the entire problem.

The present study, of which this is merely a preliminary report, embraces, in part, the results of more advanced laboratory tests, and the consideration of certain clinical aspects not hitherto included in published articles.

Is Vasomotor Rhinitis an Allergic Disease?

One of the major difficulties in the study of vasomotor rhinitis is the interpretation of the term, allergy. The term has been advanced to cover all forms of hypersensitivity and hyposensitivity. Through the initiative of Doerr,[15] we now recognize only those phenomena as allergic which show the sequence of allergen-antibody reaction. This may safely be accepted as standard.

Semenov[16] held that vasomotor rhinitis must not be confused with allergy because the histologic pattern of the former is neither that of allergy nor infection. According to this author, vasomotor rhinitis merely means that there is an erection of the erectile tissues. "The nasal blockage can be differentiated from nasal allergy by a simple cytologic test. The etiology includes rage and anger, weeping and crying, emotional and sexual activities, coldness, dampness and rebound congestion from drugs, autonomic nervous system disturbances, and lesions of the cervical sympathetic trunk."

Plan of Study

In the present study, accuracy of diagnosis was considered paramount. Essential measures were carried out for this purpose. Apart from the history and physical examination, conventional laboratory tests were performed. Since the routine tests were of no unusual significance in this investigation, no comment will be made on them. The laboratory tests of chief concern were those suggesting endocrine hyperfunction or hypofunction. In this preliminary report will be included results of basal metabolism tests and chemical determinations of the protein iodine of the blood (table 1). The effect of treatment is also listed in the table, though the therapeutic phase will be discussed separately.

Table 1. — Basal Metabolic Rate and Protein-Bound Iodine Determinations and Degree of Improvement on Thyroid Therapy

Patient	Age	Sex	Basal Metabolic Rate	Protein-Bound Iodine	Improvement Under Therapy*
ML	39	M	Minus 14	4.9	XXXX
ES	64	F	Minus 7	8.2	XX
JL	17	F	Plus 10	6.0	0
RC	34	F	Minus 5	5.0	XX
CK	28	F	Minus 11	6.3	XXX
CH	30	F	Minus 3	4.3	XXX
SW	15½	F	Minus 4	3.8	XXX
JD	50	F	Minus 21	5.7	XXXX
AL	48	M	Minus 5	8.0	X
EH	50	F	Plus 2	8.2	X
EG	14	F	Minus 8	4.0	XXXX
SS	36	F	Plus 1	6.0	X
HE	43	F	Minus 2	6.3	XX
AA	13½	F	Minus 11	6.7	XXX
AM	11	F	Minus 11 & 16	6.8	XXX
RD	57	F	Plus 10	6.0	0
EW	56	F	Plus 10	4.3	0
HV	5	F	Plus 19	7.4	0
AC	42	F	0	6.5	XX
AR	11	F	Plus 20 & 17	6.8	0
BS	60	M	Minus 5	3.7	X
SM	58	M	Plus 17	8.0	0
RM	17	M	Plus 17	6.5	0
HG	40	M	Minus 5	4.5	XXX
AP	14	M	Minus 1	4.7	XX
DC	25	F	Minus 9	5.0	XX
MD	53	M	Minus 10	4.7	XXX
RD	10	M	Plus 18	3.5	X
LL	52	F	Minus 11	4.0	XX
RF	52	F	Minus 13	5.5	XXX
SW	12	M	Plus 4	6.5	0
LL	35	F	Minus 14	6.0	XX
LE	40	F	Minus 11	4.5	XXXX
BS	49	F	Minus 13	3.0	XXXX
SK	25	F	Minus 16		XXXX
JL	50	F	Minus 18		XXXX
EW	50	F	Minus 9		XXX
DW	22	F	Minus 12		XXX
VC	41	F	Minus 9		XXX
NM	20	F	Plus 1		X
NB	30	F	Minus 11		XXXX
LK	14	M	Minus 20		XXXX
SH	13	F	Minus 1 & 6		XX
RL	21	F	Minus 9		XX
HL	14	F	Minus 8		XXX
ER	33	F	Plus 18		0
RR	15	F	Minus 8		XXX
LS	42	F	Plus 11		0
AP	14	M	Minus 4		XX
EE	48	F	Minus 12		XXX
SG	21	F	Minus 14		XXX
MK	44	F	Minus 6		XX
NG	20	F		4.5	XX
MB	38	F		4.1	XX
AR	16	F		3.5	XXX
JB	45	F		4.2	XXX

* X indicates slight improvement, XX moderate improvement, XXX considerable improvement and XXXX pronounced improvement.

Tests Employed in Study

Results of basal metabolism tests not only aided in arriving at the diagnosis, but served also as a guide to therapy (table 1). Protein-bound iodine tests were performed to ascertain whether the results ran parallel with those of the basal metabolism tests. It will be seen from table 1 that there is no parallelism.

Basal Metabolism Test. — This test measures the expenditure of energy and not the func-

tion of the thyroid gland directly. Since the result is influenced by a number of factors, its correct interpretation is important. Often this must take cognizance of all clinical and laboratory findings.

It is conceded that the test has definite limitations in accurate performance, but under favorable circumstances, it has in the past, and will continue in the future, to prove extremely useful. Seed[17] did not consider the basal metabolic rate obsolete. As a matter of fact, though he observed shortcomings and inaccuracies under certain conditions with all available tests, he found the basal metabolic rate a fairly reliable index of hypothyroidism.

Protein-Bound Iodine. — This test is extended to measure the actual concentration of thyroid hormone in the peripheral blood. In commenting on this test, Blackburn[18] stated: "Many of the proponents of this test declare possibly with more enthusiasm than accuracy, that it is not only more specific but is also a more sensitive test of thyroid function than any of its competitors. Actually, it is probably more sensitive than the basal metabolic rate. In a significant number of cases of hyperthyroidism or myxedema, values for serum protein bound iodine are within the normal range, defined by those values that include 95 per cent of normal persons, namely 3.5 to 8.5 micrograms per 100 ml."

Because the protein-bound iodine results in patients with vasomotor rhinitis do not parallel those of the basal metabolism tests, it must be assumed that they fall in the normal range as they do in a large number of cases of hyperthyroidism and myxedema. This situation does not necessarily imply an inaccurate determination because of the many influencing factors incident to this highly sensitive test. From these facts, it is obvious that in this study the practical value of the protein-bound iodine test was less than that of the basal metabolism test and served a useful purpose only in exceptional cases.

Results of Metabolism and Protein-Bound Iodine Tests

In the present study 56 patients were included. On 34, both the metabolism and the protein-bound iodine tests were performed. On 52, the basal metabolic rate was determined, while on 18 no protein-bound iodine results were obtainable. Four patients were subjected only to the protein-bound iodine test. This irregularity in tests can be explained by the fact that circumstances did not always render it feasible to perform both tests simultaneously.

In 38 of 52 patients, the basal metabolic rate was on the minus side. In 18 of 38 patients the protein-bound iodine determinations were 5.0 or under. For the purposes of this study a minus metabolism or a protein-bound iodine determination of 5.0 or under served as the indication for thyroid therapy.

Are the results of the laboratory tests to be considered the only index to therapy? The answer is emphatically no. Proetz[12,13] correctly stated in his papers on The Thyroid and the Nose: "A low basal metabolic rate is presumptive evidence; a therapeutic test conclusive."

It follows from this reasoning that patients who clinically present suggestive evidence of vasomotor rhinitis should be subjected to basal metabolism testing. If determinations do not correspond with the clinical findings, therapeutic testing with thyroid extract is in order. Although it is not usual that resort has to be had to the therapeutic test, it occasionally proves necessary.

The fact that a high percentage of patients with vasomotor rhinitis yield minus basal metabolic rate determinations is of significance. In vasomotor rhinitis, the indications for thyroid therapy are the characteristic clinical symptoms and a minus basal metabolic rate, even if the latter is in the so-called normal range of minus 10 (or 15) and plus 10 (or 15).

Dosage of Thyroid

As concerns dosage of the drug, the basal metabolic rate must serve as the guide. In adults, 1 to 1½ grains per day proves adequate, unless after a time, the basal metabolic rate fails to yield or show a change as compared with the original test. The average dose is ½ grain three times daily. In some patients, the dosage has to be stepped up, and if it appears that an increase is indicated, decision as to improvement or failure should be reserved until, in the judgment of the physician, an adequate amount of the drug has been administered. Since thyroid therapy is occasionally of some hazard, its administration should be controlled at intervals by basal metabolism testing. If the drug is well tolerated, a maintenance dose may be necessary after the nasal symptoms have abated.

In the present series pronounced improvement was obtained by 9 patients, considerable improvement by 27, and moderate improvement by 14.

It was of considerable interest to note that those patients who yielded a basal metabolic rate on the plus side failed to respond to thyroid therapy. Even though these patients presented the classical clinical symptoms and characteristics of vasomotor rhinitis, they unquestionably were erroneously classified.

General Comment

The question arises whether in the endocrinopathic type of vasomotor rhinitis one is dealing solely with a thyroid insufficiency, or whether other endocrine glands also are implicated. It should be determined whether the nasal state is a typical vasomotor rhinitis or merely the reflection of a so-called hypometabolism. McLaurin[19] described the nasal symptoms of the latter as blockage with or without a watery discharge and with or without pallor of the mucous membranes.

There has been a tendency to emphasize the role of emotional factors in vasomotor rhinitis.[20] It is not unlikely that psychogenic factors are in some manner tied in with the endocrine problem, though proof is lacking of such a relationship.

In the series of cases here reported, the favorable effect of thyroid therapy in many patients with vasomotor rhinitis leads one to believe that the profession generally has been lax in recognizing an endocrine-allergy relationship. It is clear, moreover, that there is urgent need for a more accurate definition of the term, vasomotor rhinitis. I am firmly convinced that this condition is too often confused with allergy. If Semenov[16] is correct in his viewpoint, it is necessary to revise prevailing concepts of the nature of this nasal process.

It should be emphasized here that I do not believe all cases of vasomotor rhinitis are of the endocrinopathic type. Some of the other possible causes have previously been pointed out. It should be remembered, as was stated in the introduction, "Allergic rhinitis is invariably a vasomotor rhinitis, but the latter is not invariably due to allergy."

Some brief comment is in order concerning serum cholesterol determinations in patients with vasomotor rhinitis. It is now well known that when the serum cholesterol is elevated in certain patients, it bears a reciprocal relation to the basal metabolic rate. In the present study this was confirmed in numerous instances. The pronounced uniformity of this finding rendered it more or less superfluous, therefore, to perform serum cholesterol tests in all patients.

Because of the variable strength of the U.S.P. animal products and the favorable reports of the use of Synthroid, this preparation was used exclusively in this investigation. Synthroid tablets contain L-thyroxine, the active principle of the thyroid gland as the monosodium salt, prepared synthetically in pure crystalline form. The product is marketed in scored tablets containing 0.05, 0.1, or 0.2 mg. L-thyroxine. For purposes of comparison, the activity of a 0.1 mg. tablet of Synthroid is equivalent to that of approximately 1 grain of thyroid U.S.P.

Starr and Liebhold-Schueck[21] conducted a study to evaluate sodium levothyroxin administered orally for hypothyroidism. They concluded that the dose of sodium L-thyroxin required for the production of the ideal clinical result must be found in the individual case by the determination of systemic conditions, the serum protein-bound iodine, the basal metabolic rate, and the efficiency of the patient. "Furthermore, the dosage requirement must be revised to each new case at intervals of a few months." It is the practice of these investigators to give 0.05 mg. daily by mouth, as the initial dose, with progressive increases to the level that gives the best results; this may vary from 0.2 mg. to 1.0 mg. They concluded: "Sodium L-thyroxin is an acceptable thyroid medication, with uniform chemical composition and biological potency. Its establishment as the standard thyroid drug in general practice, at an economical price, would obviate the variable strength of the U.S.P. animal products and the use of the proprietary extracts of the gland."

Conclusion

Blackburn,[18] and other workers[17] have emphasized that because of many years experience with the basal metabolism test, it probably is more useful than any other single laboratory aid in the diagnosis of disease of the thyroid gland.

Though there is no parallelism in the basal metabolic rate and protein-bound iodine determinations in vasomotor rhinitis, uniformity of results with the basal metabolism test clearly indicates that an endocrinopathic type of vasomotor rhinitis must be recognized.

Even if an out and out allergic state has to be dealt with, "allergic therapy is usually more successful if the endocrine disorder is properly controlled."[22]

Summary

Failure to recognize that vasomotor rhinitis is primarily a nonallergic disease probably accounts for the many therapeutic failures in this condition.

According to Semenov,[16] vasomotor rhinitis merely signifies that there is an erection of the erectile tissues.

The present reinvestigation of the endocrine aspect of vasomotor rhinitis has confirmed the validity of an endocrinopathic type of this disease.

Favorable results were obtained with thyroid therapy (Synthroid) in the majority of patients who showed a minus basal metabolic rate or a protein-bound iodine determination under 5.0.

Adequate management of intervening factors, more especially endocrine dysfunction, in allergic states will enhance the results of conventional allergic methods.

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605 Lincoln Road.

ABSTRACTS

Tripelennamine Hydrochloride for Topical Urethral Anesthesia. By Raymond J. Fitzpatrick, M.D., and Louis M. Orr, M.D. J. A. M. A. 158:261 (May 28) 1955.

Some two years ago these authors presented a preliminary report on the use of tripelennamine (Pyribenzamine) hydrochloride for the production of topical urethral anesthesia in which they reviewed the literature, reported their results in a series of 100 cases and suggested this antihistamine as an effective and safe topical anesthetic agent for urologic use. In the present study, with two years' additional routine use in over 2,000 patients, no untoward reactions were noted and there were practically no failures of anesthetic action. On the basis of their clinical experience with this large series, in conjunction with the knowledge of similarly good results in other specialty practices, they recommend 2 per cent solution and 2 per cent jelly of tripelennamine for use as preparations of a safe, potent, topical anesthetic agent in dosage not exceeding 300 mg. in adults.

Man, What Are You Worth? By James Basil Hall, M.D., M.P.H. Mississippi Valley M. J. 77:174-177 (Sept.) 1955.

This study of the value of the average man in dollars and cents covers an enlightening review of judgments rendered for wrongful death and malpractice judgments. It is observed that the money value of man has shown an appreciable increase during the past decades and is rising rather rapidly. The reasons given are inflation, increased life span, dignity and the National Association of Claimants Compensation Attorneys.

It is pointed out that the money value of man should be of particular interest to the practicing physician in view of the trend that is involving professional people more frequently and in larger liability suits. It is concluded that the lesson to be learned from this study is: "Man is being valued at more than $300,000; physicians deal with men; therefore we should all recognize it and carry enough protection to meet any eventuality."

Mucoceles of the Appendix and Peritoneal Pseudomyxoma. By Charles C. Carleton, M.D. A. M. A. Arch. Path. 60:30-48 (July) 1955.

The author defines mucocele as an appendix, a segment of which is dilated and filled with mucus, and reviews 13 cases, encountered at Charity Hospital, New Orleans, in a 15 year period, in which mucocele was diagnosed. Twelve of the appendices were surgically removed and one encountered at autopsy. He also reports a fairly typical case of peritoneal pseudomyxoma.

From a morphologic study of the 13 cases of mucocele and the single case of peritoneal pseudomyxoma of appendiceal origin, he concludes that the development of an appendiceal mucocele could be divided into three stages according to the type of epithelium lining it, and, while at one stage the epithelium is hyperplastic, there is nothing to suggest true malignancy. A transition from a flat serosal type lining to a mucus-containing columnar epithelium could be traced in some of the pockets of encysted mucus in the peritoneal tissues.

In his opinion the development of a generalized pseudomyxoma depends upon the rupture of a mucocele at a time when it is lined by a hyperplastic mucus-producing epithelium, and a fistula between the lumen of the appendix and the peritoneal cavity must be established. If this fistula heals or the appendix is removed, the condition is almost always arrested. The columnar cells seen in some of the peritoneal mucus collections are probably derived from the peritoneal tissue as a response to mild irritation and are not necessarily mucus-producing. Obviously, the pathogenesis of this condition is not clear and probably will remain obscure until it is reproduced experimentally.

Clinical Value of the TSH Test in the Diagnosis of Thyroid Diseases. By George A. Bishopric, M.D., Norman H. Garrett, M.D., and William M. Nicholson, M.D. Am. J. Med. 18:15-19 (Jan.) 1955.

There are common clinical diagnostic problems in which the thyroid functional state may be depressed but the capacity to function may be normal. In such situations a comparison of the activity of the thyroid gland before and after stimulation by thyrotropic hormone (TSH) has proved to be of great diagnostic value. This study is an attempt to establish the reliability of the radioactive iodine (RAI) uptake response to TSH as a diagnostic procedure, to compare the three hour and 24 hour RAI uptake responses to a single injection of TSH and to evaluate the regularity of the RAI uptake response to TSH in normal subjects receiving thyroid for reasons other than proved hypothyroidism. The procedure is described, and the results are tabulated.

In summary, the findings were: The change in the 24 hour RAI uptake of the thyroid gland after stimulation with a single injection of TSH is a reliable and valuable diagnostic aid in distinguishing between primary and secondary hypothyroidism. It is also of particular value in differentiation between primary hypothyroidism and euthyroidism in patients whose thyroid function has been suppressed by substitution therapy and whose clinical and laboratory picture otherwise is similar. The technic used, that is, a single injection of TSH and a total of only four days' observation, seems to be at least as reliable as technics involving multiple injections of TSH and much longer periods of observation. The three hour uptake response to TSH parallels the 24 hour response, but does not seem to be as safe a diagnostic aid because of relatively larger experimental error. An upper limit of increase of 10 in the 24 hour percentage uptake after TSH, and an upper limit of 15 per cent in the total 24 hour RAI uptake after TSH, seem to be the highest values acceptable for the diagnosis of primary dysfunction of the thyroid gland.

Rotating Endometrial Brush: New Technic for the Diagnosis of Fundal Carcinoma. By J. Ernest Ayre, M.D. Obstetrics and Gynecology 5:137-141 (Feb.) 1955.

A rotating endometrial brush for use as a diagnostic tool in the detection of benign and malignant neoplasms of the uterine body is described. It is concluded that the rich concentrations of endometrial cells which may be procured in a rapid office procedure should increase the accuracy of cytologic diagnosis of uterine (body) carcinoma. The technic is described, and the false negative diagnosis of endometrial cancer, the cytologic considerations and the indications for the use of the endometrial brush are discussed.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 1018, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

Florida Medical Association

82nd

ANNUAL CONVENTION

May 13, 14, 15, 16, 1956



HOTEL

Fontainebleau

MIAMI BEACH

Out-of-State Convention Speakers



SHIELDS WARREN, M.D.
Professar af Pathology,
The Harvard Medical School;
President, American Board af
Pathalagy, Boston



JAMES J. CALLAHAN, M.D.
Professor af Bone and Jaint Surgery,
Stritch School af Medicine,
Loyola University, Chicago



LAUREN H. SMITH, M.D.
Physician-in-Chief and Administr
The Institute, Pennsylvania Hosp
Philodelphia

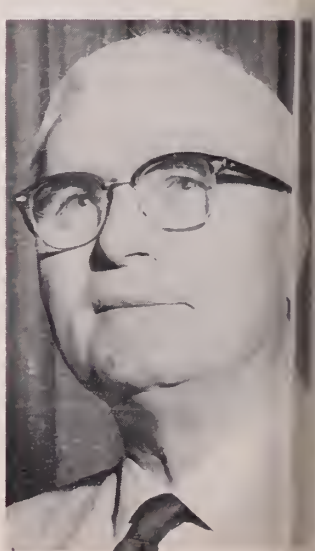
Eminent Guests



ELMER HESS, M.D.
President, American Medical
Assaciation,
Erie, Pa.



DWIGHT H. MURRAY, M.D.
President-Elect, American Medical
Associotion, Napa, Calif.



JOHN R. FOWLER, M.D.
President, American Academy
General Practice, Barre, Mass.



John W. Cline, M. D., Guest Speaker

Dr. John W. Cline, San Francisco, is assistant clinical professor of surgery at Stanford University Medical School. He is a member of the staff of Stanford University Hospital, is assistant visiting surgeon at San Francisco Hospital and associate surgeon at Children's Hospital in San Francisco.

He is a member of the American College of Surgeons, the Pacific Coast Surgical Association and is a diplomate of the American Board of Surgery.

A native of California, Dr. Cline is a graduate of the University of California and The Harvard Medical School. Upon completion of medical school, he served two years as house officer at the Massachusetts General Hospital at Boston and two years as a resident surgeon at Bellevue Hospital in New York. He then returned to San Francisco to engage in the practice of medicine.

Dr. Cline is a past president of the American Medical Association. He was chosen president-elect at the annual meeting in San Francisco in June, 1950, and succeeded the late Dr. Elmer L. Henderson as president the following year.

He is also a past president of the San Francisco County Medical Society and the California Medical Association. He served on the Association's Council for many years and is a former member of the House of Delegates of the American Medical Association.

This distinguished surgeon is no stranger to physicians of Florida. It will be remembered that he was principal speaker at the Second Annual Meeting of the Florida Medical Committee for Better Government held at Miami, October 5-7, 1951.

PROGRAM

Eighty-Second Annual Meeting

FLORIDA MEDICAL ASSOCIATION

HOTEL FONTAINEBLEAU

Miami Beach

May 13, 14, 15 and 16, 1956

Registration

The Registration Desk will be located in the Foyer just beyond the Scientific Exhibits in the Hotel Fontainebleau and will be open Sunday, Monday and Tuesday, 8:30 a.m. to 5:30 p.m., and Wednesday 8:30 a.m. to 12:30 p.m. Each member will be required to register and obtain an identification badge before attending any of the sessions. Guests and ladies are required to register at the Registration Desk and obtain their badges.

There is no fee for registration. Printed programs may be obtained at the Registration Desk.

Convention Headquarters

The general headquarters will be the Hotel Fontainebleau where the registration desk, assembly room for general sessions, meeting place of the House of Delegates, scientific assemblies, information desk and technical and scientific exhibits will be located.

The specialty groups approved by the Board of Governors will meet Saturday and Sunday in the Hotel Fontainebleau, San Marino Hotel and Sorrento Hotel.

Hotels

HOTEL FONTAINEBLEAU — HOTEL HEADQUARTERS
(European Plan)

Single or double occupancy	$12, $14, $16, $20
Parlor-Bedroom suites	$38, $45
Parlor-Two Bedroom suites	$75

SAN MARINO HOTEL
(European Plan)

Single or double occupancy	$ 8, $10, $12

SORRENTO HOTEL
(European Plan)

Single or double occupancy	$ 8, $10, $12

SOVEREIGN HOTEL
(European Plan)

Single or double occupancy	$ 8, $10, $12

LUCERNE HOTEL
(European Plan)

Single or double occupancy	$10, $12, $14

Since the hotels are on European Plan, it will be necessary for each guest to individually provide gratuities in the dining rooms, etc. Average gratuities are 15 per cent for food and ten per cent for beverages.

Golf

The Florida Medical Association Golf Tournament will be held at the Bayshore Golf Course on May 14 and 15. Dr. Julian A. Rickles, of Miami, is chairman of the Golf Committee. Assisting him are Drs. Mathew W. Kobak, Richard E. Strain, Donald G. Stannus and Leo M. Levin, all of the Miami area.

Association members will compete for the Orlando Loving Cup (low net) and the Duval County Society Trophy (low gross).

The Orlando Loving Cup was donated by the Orange County Medical Society in 1931 following an annual meeting of the Association there. The Duval County Medical Society donated its trophy in 1952 at an Association annual meeting in Hollywood.

Dr. Joseph L. Hundley, of Orlando, won the Orlando Loving Cup at the Tournament in St. Petersburg last year. Dr. Curtis D. Benton Jr., of Fort Lauderdale, won the Duval Trophy.

Members of the Auxiliary will stage their annual tournament at the same course and under the same conditions as the men. They will have a separate list of prizes including an annual trophy presented by the Orange County Medical Society to the holder of the low gross score.

Those desiring further information are asked to communicate with Dr. Julian A. Rickles, chairman, Golf Committee, 2627 Biscayne Blvd., Miami.

Anglers

Members interested in fishing should contact Dr. Hollis F. Garrard or Dr. Milton B. Jacobson, chairman and co-chairman respectively of the Anglers Committee. Dr. Garrard's address is 410 Ingraham Building, Miami, and Dr. Jacobson may be contacted at 802 Huntington Building, Miami.

Vouchers for Prizes

At Association Dinner
GOLF AND OTHER SPORTS EVENTS

Patio Party

Dr. Jack J. Falk is chairman of the committee on arrangements for the patio party. This fellowship and cocktail hour scheduled for 7:00 p.m., will immediately precede (for one hour only) the annual dinner and will be held in the Pavillon area, Hotel Fontainebleau.

Tickets for the Patio Party will be on sale at the registration desk ($3.50 per person). Informal entertainment appropriate to the occasion is being arranged.

Association Dinner

The annual dinner is being held in the Pavillon of Hotel Fontainebleau on Tuesday evening at 8:00 p.m. Tickets at $9.00 per person may be purchased at the Registration Desk.

Convention Committees

General Co-Chairmen
David A. Nathan and Alfred G. Levin

PATIO PARTY
Jack J. Falk, *Chairman*

John H. Tanous	William Wickman
William S. Weinkle	Victor H. Kugel



A typical scene on the Bayshore Golf Course where the Florida Medical Association Golf Tournament is to be held.

GOLF
Julian A. Rickles, *Chairman*
Virgil H. Pieck — Donald G. Stannus
Mathew W. Kobak — Leo M. Levin
Richard E. Strain

ANGLERS
Hollis F. Garrard, *Chairman*
Milton B. Jacobson, *Co-Chairman*
David Kirsh — Robert F. Dickey
Bernhard Baer — W. Tracy Haverfield

GREETERS
Reuben B. Chrisman Jr., *Chairman*
Sherman R. Kaplan, *Co-Chairman*
James J. Hutson — Theodore M. Berman
Stanley Frehling — Franz H. Stewart
Elliott C. Cohen — Donald F. Marion
Frank M. Woods — Morris H. Blau

TRANSPORTATION AND HOUSING
Louis G. Lytton, *Chairman*
Paul K. Jenkins — Oliver P. Winslow Jr.
Saul H. Kaplan — Nicholas A. Tierney

LADIES' ADVISORY COMMITTEE
Nelson Zivitz, *Chairman*
Richard M. Fleming — John F. Hauss
Lewis Capland — Harold Rand

SATURDAY AND SUNDAY

May 12-13

SPECIALTY GROUP MEETINGS

Rooms have been assigned to the various specialty group societies on Saturday and Sunday in the Hotel Fontainebleau, San Marino and Sorrento Hotels. The State Association is not to furnish projecting lanterns or any of the equipment necessary for the holding of such meetings.

EIGHTH ANNUAL MEETING FLORIDA **ALLERGY** SOCIETY

OFFICERS

W. Ambrose McGee, President West Palm Beach
Edwin P. Preston, Vice Pres. and Pres.-elect Miami
Norris M. Beasley, Secy.-Treas. Fort Lauderdale

Sunday, May 13

HOTEL FONTAINEBLEAU — SOUTH CARD ROOM

8:00 p.m.
1. "Rehabilitation of the Intractable Asthmatic Child," Harold Tuft, Clinical Director, National Jewish Home for Asthmatic Children, Denver, Colo.
2. "Clinical Investigation of Allergens Peculiar to Tropics and Subtropics."
 Panel Discussion: Nelson Zivitz, Moderator, Miami Beach; Morton L. Hammond, Miami; George Gittelson, Miami; Jack A. Rudolph, Miami, and Miss Lillian Fly, Dept. of Botany, University of Miami.
3. "Dynamics of the Anaphylactic Reaction," Virgil Moon, Resident Professor of Medical Research, University of Miami.



The pool and a portion of the grounds of the Hotel Fontainebleau.

EIGHTH ANNUAL MEETING FLORIDA SOCIETY OF **ANESTHESIOLOGISTS**

OFFICERS

Wayland T. Coppedge Jr., President Jacksonville
Harry E. Bierley, Pres.-elect West Palm Beach
Stanley H. Axelrod, Vice Pres. Miami Beach
John T. Stage, Secy.-Treas. Jacksonville

Sunday, May 13

SAN MARINO HOTEL — CARD ROOM

2:00 p.m. Business Meeting and Election of Officers

REGULAR MEETING OF THE FLORIDA ASSOCIATION OF **DERMATOLOGY** AND **SYPHILOLOGY**

OFFICERS

Joseph L. Hundley, President Orlando
Joseph A. J. Farrington, Vice Pres. Jacksonville
Kenneth J. Weiler, Secy.-Treas. St. Petersburg

Saturday, May 12

Place to be Announced

6:30 p.m. Cocktail Party

Sunday, May 13

Place to be Announced

10:00 a.m. Clinic
12:30 p.m. Luncheon

EIGHTH ANNUAL MEETING FLORIDA CHAPTER AMERICAN COLLEGE OF **CHEST PHYSICIANS**

OFFICERS

Hawley H. Seiler, President Tampa
Jack Reiss, Vice Pres. Coral Gables
William L. Potts, Secy.-Treas. Jacksonville
Clarence M. Sharp, Program Chairman Jacksonville

Sunday, May 13

SAN MARINO HOTEL — BALBOA ROOM (ground floor)

9:00 a.m. Business Meeting
9:45 a.m. Scientific Program
"What is the Present Day Management of Pulmonary Tuberculosis?"
Panel Discussion: Jack Reiss, Coral Gables, Moderator; Benjamin L. Brock, Orlando, Sanatorium Director; Lawrence H. Kingsbury, Orlando, Thoracic Surgeon; Phillip W. Horn, Jacksonville, Private Physician, and Clarence L. Brumback, West Palm Beach, Public Health Physician.
10:45 a.m. "Evaluation of Pulmonary Function," Philip Samet, Miami Beach.
Discussion Leader: George L. Baum, Coral Gables

11:25 a.m. "The Technique and Value of Bronchography in the Diagnosis of Pulmonary Disease," Robert T. Rengarts, Fort Lauderdale.
Discussion Leader: Ivan C. Schmidt, West Palm Beach

2:00 p.m. Scientific Program
"Detection of Congenital Heart Disease by X-Ray Surveys," Simon D. Doff, Jacksonville.
Discussion Leader: Francisco A. Hernandez, Miami

2:40 p.m. "Cardiovascular Surgery in the Average Community," Edward R. Munnell, Oteen, N. C.

3:30 p.m. "Indications for Surgery in Coronary Heart Disease," Sidney Smith, Bradenton.
Discussion Leader: Franz H. Stewart, Miami

4:15 p.m. X-Ray Seminar, M. Jay Flipse, Miami, Moderator. (Those in attendance requested to bring x-rays for discussion after presenting a brief and pertinent clinical history.)

All physicians of the Florida Medical Association and guests are cordially invited to attend.

TENTH ANNUAL MEETING FLORIDA ACADEMY OF **GENERAL PRACTICE**

OFFICERS

Frank T. Linz, President — Tampa
Leo M. Wachtel, Pres.-elect — Jacksonville
Leon S. Eisenman, Vice Pres. — Hialeah
James B. Hodge Jr., Secy.-Treas. — Tampa

Sunday, May 13

HOTEL FONTAINEBLEAU — LA RONDE ROOM

12:45 p.m. Board Meeting
2:00 p.m. Scientific Session: "The Family Physician and the Cripple," John R. Fowler, President, American Academy of General Practice, Barre, Mass.
2:45 p.m. Business Session

ELEVENTH ANNUAL MEETING FLORIDA **HEALTH OFFICERS'** SOCIETY

OFFICERS

Clarence L. Brumback, President — West Palm Beach
Merwin E. Buchwald, Vice Pres. — Fort Myers
Lorenzo L. Parks, Secy.-Treas. — Jacksonville

Sunday, May 13

SAN MARINO HOTEL — FLORENTINE ROOM

2:00 p.m. "Determining Immunity in a County," Joseph W. Lawrence, Arcadia.
Discussion: James O. Bond, Jacksonville

2:20 p.m. "Syphilis in Polk County — A Report of the 1955 Blood Testing Survey," James A. Donaldson, Winter Haven, and J. R. Ackerman, Jacksonville.
Discussion: Chester L. Nayfield, Winter Haven, Miami.

2:40 p.m. "The Physician's Relationship with Other Members of the Team," Maurice H. Greenhill, Miami.
Discussion: W. Laney Whitehurst, Jacksonville

3:10 p.m. "The Cost of Administration of the Salk Vaccine Program," Warren T. Weathington, Apalachicola, and Joseph M. Bistowish, Tallahassee.
Discussion: Wade N. Stephens, Orlando

3:30 p.m. "A Study of the Risk of Ascaris Infection in the Use of Sludge as a Fertilizer," James O. Bond, Jacksonville.
Discussion: Frank V. Chappell, Tampa

3:50 p.m. "A Study of What People Eat," Marjorie Morrison, M.S., Jacksonville.

4:10 p.m. Business Session

SEVENTEENTH ANNUAL MEETING FLORIDA ASSOCIATION OF **INDUSTRIAL** AND **RAILWAY SURGEONS**

OFFICERS

Frank L. Fort, President — Jacksonville
Herschel G. Cole, Pres.-elect — Tampa
Courtland D. Whitaker, Vice Pres. — Marianna
John H. Mitchell, Secy.-Treas. — Jacksonville

Sunday, May 13

SORRENTO HOTEL — CLUB ROOM

2:00 p.m. Business Session; Election of officers
3:00 p.m. Scientific Session
1. "Wrist and Hand Injuries and Fractures," James J. Callahan, M.D., Professor of Bone and Joint Surgery, Stritch School of Medicine, Loyola University; Professor, Bone and Joint Surgery, Cook County School of Medicine; Vice President, Cook County School of Medicine; Chief, Division of Fractures, Chicago.

Note: The Scientific Session of The Florida Association of Industrial and Railway Surgeons and the Orthopedic Groups will be held at the same time — 3:00 p.m., Club Room, Sorrento Hotel, Miami Beach.
The Orthopedic Group will furnish a speaker for this meeting also.

TENTH ANNUAL MEETING FLORIDA SOCIETY OF **NEUROLOGY** AND **PSYCHIATRY**

OFFICERS

Edward H. Williams, President — Miami
Roger E. Phillips, Vice Pres. — Orlando
J. Robert Campbell, Secy.-Treas. — Tampa

Saturday, May 12

HOTEL FONTAINEBLEAU — ROSEWOOD ROOM

10:30 a.m. Business Meeting
2:00 p.m. Round Table Discussion: "Psychodynamics and Its Implication in Diagnosis, Psychotherapy and Psychosomatic Problems."
Moderator: Martha W. MacDonald, Sarasota.
Speakers: Samuel R. Warson, "Diagnostic Criteria," Sarasota; Herman Selinsky, "Psychotherapy," Miami, and Maurice H. Greenhill, "Psychosomatic Aspects," Miami.

HOTEL FONTAINEBLEAU — PAVILLON

6:00 p.m. Cocktails.
7:00 p.m. Dinner. After dinner speaker to be announced.

Sunday, May 13

HOTEL FONTAINEBLEAU — ROSEWOOD ROOM

9:30 a.m. "Dynamic Aspects of Personality of Problem Drinkers," John E. Wright, Miami.
10:30 a.m. "Somatic Therapies in Psychiatry," Lauren H. Smith, Physician-in-Chief and Administrator of The Institute of the Pennsylvania Hospital, Philadelphia, Pa.; Professor of Psychiatry, School and Graduate School of Medicine, University of Pennsylvania, Philadelphia.
2:00 p.m. Business Meeting and Election of Officers.

NINTH ANNUAL MEETING FLORIDA **OBSTETRIC** AND **GYNECOLOGIC** SOCIETY

OFFICERS

J. Champneys Taylor, President — Jacksonville
S. L. Watson, Pres.-elect — Lakeland
Reuben B. Chrisman Jr., Secy.-Treas. — Coral Gables

Sunday, May 13

HOTEL FONTAINEBLEAU — NORTH CARD ROOM

2:00 p.m. Business Session and Election of Officers
2:30 p.m. Scientific Session
1. "The Early Diagnosis and Treatment of Adnexal Malignancy."
2. "The Management of Ectopic Pregnancy."

3. "Pelvic Pain."
Speaker: Frank R. Smith, Associate Professor of Clinical Obstetrics and Gynecology at Cornell University Medical College; Chief, Gynecology Service, Roosevelt Hospital; Attending Obstetrician and Gynecologist, New York Hospital; Associate Attending Gynecologist, Memorial Center for Cancer and Allied Diseases, New York.

6:00 p.m. Cocktails (Location to be announced)

SEVENTEENTH ANNUAL MEETING FLORIDA SOCIETY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

Officers

Charles W. Boyd, President Jacksonville
Blackburn W. Lowry, Pres.-elect Tampa
Carl S. McLemore, 1st Vice Pres. Orlando
Edson J. Andrews, 2nd Vice Pres. Tallahassee
Kenneth S. Whitmer, Secy.-Treas. Miami

Sunday, May 13

Hotel Fontainebleau — Boom Boom Room

10:00 a.m. Scientific Session
1. President's Address, Charles W. Boyd, Jacksonville.
2. "The Relationship of Speech Disorders to Clinical Otolaryngology," Mr. Lester L. Hale, Professor of Speech, University of Florida.
3. "Ocular Injuries and Their Complications," Banks Anderson, Chief of Ophthalmology, Duke University, Durham, N. C.
4. Annual Report of Florida Council for the Blind, Mr. Harry E. Simmons, Executive Director.

2:00 p.m. Scientific Session
1. "Clinical Management of Traumatic Hyphemia," Thomas G. Dickinson, Sarasota.
Discussion: Joseph W. Taylor Jr., Tampa
John F. McKenna, Miami
2. "Tracheotomy in Secretory Obstruction," J. Allan Fields, Fort Lauderdale.
Discussion: Louis H. Clerf, St. Petersburg
3. Business Meeting
4. Election of Officers

Cocktail Party (Location to be announced)

TENTH ANNUAL MEETING FLORIDA ORTHOPEDIC SOCIETY

Officers

Edward W. Cullipher, President Miami
Luther C. Fisher Jr., Vice Pres. Pensacola
Robert P. Keiser, Secy.-Treas. Coral Gables

Sunday, May 13

Sorrento Hotel — Card Room

2:00 p.m. Business Meeting
3:00 p.m. Joint Meeting with Florida Association, Industrial and Railway Surgeons — Club Room
6:00 p.m. Cocktails (Location to be announced)

FOURTEENTH ANNUAL MEETING FLORIDA SOCIETY OF PATHOLOGISTS

Officers

Millard B. White, President Sarasota
John W. Williams, Vice Pres. Lakeland
Wray D. Storey, Secretary Tampa
James B. Leonard, Treasurer Clearwater

Sunday, May 13

Hotel Fontainebleau — Board Room

9:00 a.m. Business Meeting
2:00 p.m. "The Pathologist's Responsibility for Radioisotopes," Shields Warren, Professor of Pathology, The Harvard Medical School; President, American Board of Pathology, Boston.

TWENTY-THIRD MEETING FLORIDA PEDIATRIC SOCIETY

Officers

Wesley S. Nock, President Coral Gables
Joel V. McCall Jr., Pres.-elect Daytona Beach
Henry G. Morton, Secy.-Treas. Sarasota

Sunday, May 13

Hotel Fontainebleau — Civic Room

Joint meeting with the Florida Chapter of the American College of Surgeons.

2:00 p.m. "Controversial Subjects in Pediatric Surgery," Robert E. Gross, Surgeon-in-Chief, Children's Hospital, The William E. Ladd Professor of Children's Surgery, The Harvard Medical School, Boston.
3:00 p.m. Panel Discussion: Robert E. Gross, Boston; C. Jennings Derrick, West Palm Beach; Hugh A. Carithers, Jacksonville; Kenneth A. Morris, Jacksonville, and Sidney Smith, Bradenton.

Hotel Fontainebleau — Rosewood Room

4:00 p.m. Business Meeting, Florida Pediatric Society
4:45 p.m. Business Meeting, Florida Chapter of the American Academy of Pediatrics
5:00 p.m. Cocktail Party, Florida Pediatric Society. Courtesy, Mead Johnson & Co.
7:00 p.m. Dinner

Hotel Fontainebleau — Civic Room

Joint Meeting with the Florida Chapter of the American College of Surgeons.

8:00 p.m. "Problems of the Pediatric Surgeon," Robert E. Gross, Boston.

NINTH ANNUAL MEETING FLORIDA PROCTOLOGIC SOCIETY

Officers

Thomas F. Nelson, President Tampa
R. Sam Mosley, Vice Pres. Miami
George Williams Jr., Secy-Treas. Miami

Saturday, May 12

Hotel Fontainebleau — North Card Room

10:00 a.m. (Program not received in time for publication)

TWENTY-FIFTH ANNUAL SPRING MEETING FLORIDA RADIOLOGICAL SOCIETY

Officers

Hugh G. Reaves, President Sarasota
James T. Shelden, Vice Pres. Lakeland
Donald H. Gahagen, Secy.-Treas. Fort Lauderdale

Saturday, May 12

Hotel Fontainebleau — Civic Room

2:00 p.m. Round Table Discussion — Diagnosis

Hotel Fontainebleau — Rosewood Room

8:00 p.m. Dinner

Sunday, May 13

Hotel Fontainebleau — North Card Room

10:00 a.m. Business Session and Election of Officers

ANNUAL MEETING FLORIDA CHAPTER AMERICAN COLLEGE OF SURGEONS

Officers

Joseph S. Stewart, President Miami
Frederick H. Bowen, Vice Pres. Jacksonville
C. Frank Chunn, Secy-Treas. Tampa

Sunday, May 13

Hotel Fontainebleau — Civic Room

10:00 a.m. 1. "The Management of Hormonal Influenced Shifts of Fluids, Electrolytes, and Colloids in Stress," Donald W. Smith, Miami.
2. "Choosing Therapy for the Patient with Arteriosclerosis of the Lower Extremities," Edward A. Edwards, Associate Clinical Professor of Anatomy, The Harvard Medical School and Associate in Surgery, Peter Bent Brigham Hospital, Boston, Mass.

2:00 p.m. Joint Meeting with the Florida Pediatric Society "Controversial Subjects in Pediatric Surgery," Robert E. Gross, Surgeon-in-Chief, Children's Hospital; The William E. Ladd Professor of Children's Surgery, The Harvard Medical School, Boston, Mass.
Panel on Pediatric Surgery
Speakers: Robert E. Gross, Boston; Hugh A. Carithers, Jacksonville; C. Jennings Derrick, West Palm Beach; Kenneth A. Morris, Jacksonville, and Sidney Smith, Bradenton.

8:00 p.m. Joint Meeting with the Florida Pediatric Society
"Problems of the Pediatric Surgeon," Robert E. Gross, Boston.

NINTH ANNUAL MEETING FLORIDA **UROLOGICAL** SOCIETY

OFFICERS

David W. Goddard, President	Daytona Beach
Frank J. Pyle, Pres.-elect.	Orlando
W. Dotson Wells, Secy.-Treas.	Fort Lauderdale

Sunday, May 13

HOTEL FONTAINEBLEAU — SOUTH CARD ROOM

11:00 a.m. Executive Committee Meeting.

2:00 p.m.
1. Intravenous Urography," Edwin P. Alyea, Durham, N. C.
2. Pyelogram Conference
3. Business Meeting
4. Election of Officers
5. Cocktail Party
(Location to be announced)

ANNUAL MEETING FLORIDA **CANCER** COUNCIL

Ashbel C. Williams, Chairman	Jacksonville
Lorenzo L. Parks, Secretary	Jacksonville
Frazier J. Payton	Miami
George W. Morse	Pensacola
Paul J. Coughlin	Tallahassee
Wilson T. Sowder	Jacksonville
Chas. J. Collins	Orlando

Sunday, May 13

HOTEL FONTAINEBLEAU — PARLOR TO BE ASSIGNED

9:00 p.m. Business Meeting

ELEVENTH ANNUAL MEETING **BLUE SHIELD** OF FLORIDA

OFFICERS

Russell B. Carson, M.D., President	Fort Lauderdale
Meredith Mallory, M.D., Vice Pres.	Orlando
William C. Blake, M.D., Vice Pres.	Tampa
John T. Stage, M.D., Secretary	Jacksonville
H. A. Schroder, Asst. Secretary	Jacksonville
Floyd K. Hurt, M.D., Treasurer	Jacksonville
Samuel M. Day, M.D., Asst. Treasurer	Jacksonville

Sunday, May 13

HOTEL FONTAINEBLEAU — BOARD ROOM

5:00 p.m. Meeting, Board of Directors

HOTEL FONTAINEBLEAU — NORTH CARD ROOM

8:00 p.m. Annual Meeting

MONDAY

May 14

FIRST GENERAL SESSION

Monday, 9:00 to 9:30 a.m.

HOTEL FONTAINEBLEAU — LA RONDE ROOM

Call to Order, John D. Milton, President
Invocation, Dr. Lewis N. Head, Coral Gables Methodist Church, Coral Gables.
Address of Welcome, Hunter B. Rogers, Miami, President, Dade County Medical Association.
Introduction—Elmer Hess, President, American Medical Association, Erie, Pa.; Fraternal Delegates other states.
Announcements
Adjournment

SCIENTIFIC ASSEMBLIES

Committee on Scientific Work: Donald F. Marion, Chairman, Miami; Scottie J. Wilson, Fort Lauderdale; Richard C. Cumming, Ocala; Arthur J. Butt, Pensacola; Richard Reeser Jr., St. Petersburg.

Attention is called to the following By-Laws:

"All papers read before the Association shall be its property. Every paper shall be deposited with the Secretary when read."

"No address or paper before the Association, except those of the president and orator, shall occupy more than fifteen minutes in its delivery, and no member shall speak longer than five minutes, or more than once on any one subject."

FIRST SCIENTIFIC ASSEMBLY

Monday, 9:30 a.m. to 12:30 p.m.

HOTEL FONTAINEBLEAU — LA RONDE ROOM

9:30 a.m. "Research Plan for Florida's Permanently and Totally Disabled Indigents: Analysis of 1500 Cases," Turner Z. Cason, Jacksonville.

10:00 a.m. "The First Decade of Atomic Medicine," Shields Warren, Professor of Pathology, The Harvard Medical School; President, American Board of Pathology, Boston.

10:30 a.m. "Future of Mental Health in Florida," Wilson T. Sowder, Jacksonville, and William D. Rogers, Chattahoochee.

11:00 a.m. "Intertrochanteric Fractures and Fractures of the Neck of the Femur," James J. Callahan, Professor of Bone and Joint Surgery, Stritch School of Medicine, Loyola University, Chicago.

11:30 a.m. "The Therapeutic Application of Ultrasound Energy; Results of a Broad Clinical Survey," Kenneth Phillips, Miami; Robert R. Harriss, Hollywood; Leigh F. Robinson, Fort Lauderdale, and Edward F. Carter Sr., Tampa.

12:00 a.m. "Electrophoresis in Clinical Medicine," Charles Catanzaro, Tampa.
Discussion: Nelson A. Murray, Jacksonville
John B. Miale, Miami

SECOND SCIENTIFIC ASSEMBLY

Monday, 2:00 to 5:00 p.m.

HOTEL FONTAINEBLEAU — LA RONDE ROOM

2:00 p.m. "Skin Problems Associated with Aging," Morris Waisman, Tampa.
Discussion: Wiley M. Sams, Miami
Lewis Capland, Miami Beach

2:30 p.m. "Ganglionic Blocking Agents in Treatment Hypertension," Morton M. Halpern, Coral Gables.

3:00 p.m. "The Management of Chronic Uremia," Warren Lindau, Coral Gables.

3:30 p.m. "Ulcerative Proctitis," Thomas E. McKell, Tampa.

4:00 p.m. "Vagal Arrhythmias in Succinycholine—Modified Electroshock Therapy," Henry R. Cooper, Fort Lauderdale.

4:30 p.m. "A Physiologic Approach to the Problem of Vascular Disease of the Brain," Peritz Scheinberg, Miami.
Discussion: Theodore J. C. Von Storch, Miami
Vernon T. Grizzard, Jacksonville

ALUMNI AND FRATERNITY LUNCHEONS AND SUPPERS

Monday — Hotel Fontainebleau

Theta Kappa Psi
Rosewood Room

12:30 p.m. Luncheon

All attending must register with the young lady at a marked table in the lobby.

It is doubtful we will ever hold a function in more glamorous surroundings as the Hotel Fontainebleau is one of the show places of the nation. Come and meet your fellow fraternity brothers, members of the newly created MU UPSILON Chapter, University of Miami, and members of the Grand Council who will be present.

Tulane
Rosewood Room

The Florida Tulane Medical Alumni will hold a dinner in the Rosewood Room at 7:30 p.m., preceded by a social hour at 6:30 p.m. After dinner there will be a short talk by our beloved and distinguished Dean of the School of Medicine, Dr. M. E. Lapham. Members, wives, grown children and friends invited. All attending must register with the young lady at a marked table in the lobby. Plan to attend, meet your fellow Tulanians and have fun in these fabulous surroundings.

Jefferson

7:00 p.m. Supper
Address: "Improved Adrenal Denervation for Essential Hypertension," Sherman A. Eger, Clinical Professor of Surgery, Jefferson Medical College of Philadelphia, Philadelphia.

TUESDAY

May 15

FIRST MEETING HOUSE OF DELEGATES

Tuesday, 9:00 a.m.

Hotel Fontainebleau — La Ronde Room

Delegates assemble at the Credentials Committee table at the entrance to the La Ronde Room at 9:00 a.m. to present their credentials, fill out attendance cards and receive special badges from the Credentials Committee:

Ralph W. Jack, Chairman
William C. Roberts
Jere W. Annis

Delegates are to occupy seats in the designated reserved section in order that they may be grouped together. Other members of the Association and guests are requested to occupy seats in the other sections of the room.

9:30 a.m., President Milton in the Chair

Parliamentarian for the President — George F. Schmitt Jr.

Number of eligible Delegates present. Report by Ralph W. Jack, Chairman, Credentials Committee

Motion to seat Delegates if a quorum is present

Adoption of minutes as published in June 1955 Journal
Gavel to First Vice President, Thomas C. Kenaston

President's Address, John D. Milton

President Resumes Chair

Recognition — John R. Fowler, M.D., Pres. American Academy Gen. Practice, Barre, Mass.

Recognition of Woman's Auxiliary and other guests

Reports: Homer L. Pearson Jr., Secretary, State Board of Medical Examiners, and Mr. Jack Eff, President, Miami Student Medical Association

Election of two Delegates and two Alternates to A.M.A. House of Delegates for two year terms beginning January 1, 1957

(Terms expiring December 31, 1956 — Delegate, Reuben B. Chrisman, Jr.; Alternate, Frank D. Gray

Delegate, Francis T. Holland; Alternate, Thomas H. Bates)

(A.M.A. By-Laws, Chapter IX, Sec. 1: "In order to be eligible for membership in the House of Delegates, a physician must have been an Active or Service Member of the American Medical Association for at least the two years immediately preceding the session of the House in which he is to serve.")

Reference Committee Personnel announced by President

Presentation of Resolutions and Supplemental Reports
(Resolutions not included in House of Delegates Handbook and supplemental additions to annual reports of chairmen of committees should be typed in duplicate and placed on the Speaker's table immediately after they are presented.)

Reports of Committee Chairmen and Resolutions:

(To Reference Committee No. 1)

Scientific Work, Donald F. Marion
Medical Postgraduate Course, Turner Z. Cason
Cancer Control, Ashbel C. Williams
Venereal Disease Control, A. Buist Litterer
Tuberculosis and Public Health, Lawrence C. Manni
Maternal Welfare, E. Frank McCall
Child Health, Warren W. Quillian
Blood, Louis E. Pohlman
Mental Health, Sullivan G. Bedell

Resolution: Recommendation to Blue Cross Relating to Visiting Nurse Association — Sarasota County Medical Society

Resolution: Fluoridation Public Water Supplies — Orange County Medical Society.

Resolution: Blood Donor Program — Dade County Medical Association

(To Reference Committee No. 2)

Conservation of Vision, Hugh E. Parsons
Medical Education and Hospitals, Jack Q. Cleveland
Medical Economics, Robert E. Zellner
State Controlled Medical Institutions, Edward H. Williams
Representatives to Industrial Council, John H. Mitchell
Grievance, Herbert E. White
Nursing, Jere W. Annis

Resolution: Review Working Agreement with National Foundation of Infantile Paralysis — Sarasota County Medical Society

Resolution: Studies on Degrees of Indigency — Leon-Gadsden - Liberty-Wakulla-Jefferson County Medical Society

Resolution: Advertising on Prescription Blanks — Pinellas County Medical Society

(To Reference Committee No. 3)

Board of Governors, John D. Milton
Necrology, Walter W. Sackett Jr.
Advisory to Woman's Auxiliary, Wiley M. Sams
Councilor Districts and Council, Ralph W. Jack
Advisory to Selective Service for Physicians and Allied Specialists, J. Rocher Chappell
Emergency Medical Service, Rowland E. Wood

Resolution: Expenses of Association Officials — Orange County Medical Society

(To Reference Committee No. 4)

Legislation and Public Policy, H. Phillip Hampton

Resolution: Study of Driver Licensing Law—Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society

New Business

Announcements

Adjournment

SECOND GENERAL SESSION

Tuesday, 11:30 a.m.

HOTEL FONTAINEBLEAU — LA RONDE ROOM

Call to Order, John D. Milton, President

Introduction—Dwight H. Murray, President-Elect, American Medical Association, Napa, Calif.

Address (By Invitation), "Biliary Tract Surgery," John W. Cline, San Francisco, Calif.

Adjournment

THIRD SCIENTIFIC ASSEMBLY

Tuesday, 2:00 to 5:00 p.m.

HOTEL FONTAINEBLEAU — LA RONDE ROOM

2:00 p.m. "Surgical Dysphagia," Martin G. Gould, Fort Pierce.

2:30 p.m. "Emergency Management of Acute Cranial Trauma," Albert J. Ehlert, Miami.
Discussion: Benjamin H. Sullivan, St. Petersburg
Vernon T. Grizzard, Jacksonville

3:00 p.m. "A New Era of Therapy in Psychiatry," Lauren H. Smith, Physician-in-Chief and Administrator, The Institute, Pennsylvania Hospital, Philadelphia.

3:30 p.m. "Spontaneous Abortion: A Physician Speaks to His Patient," John J. Fisher, Jacksonville.
Discussion: J. M. Ingram Jr., Tampa
Max Suter, Jacksonville

4:00 p.m. "Whiplash Injuries to Spine," Lyle W. Russell, Miami.

4:30 p.m. "Non-Penetrating Abdominal Trauma," John J. Farrell, Miami.

REFERENCE COMMITTEES

Tuesday, 2:30 p.m.

HOTEL FONTAINEBLEAU

The four reference committees will meet on Tuesday at 2:30 p.m. The names of the delegates who have been appointed by President Milton to serve on reference committees are listed below:

1. HEALTH AND EDUCATION
Civic Room

Warren W. Quillian, Chairman
Jere W. Annis
Donald F. Marion
John E. Maines Jr.
A. Judson Graves

2. PUBLIC POLICY
Boom Boom Room

Francis H. Langley, Chairman
Chas. J. Collins
S. Carnes Harvard
Walter E. Murphree
Edward Jelks

3. FINANCE AND ADMINISTRATION
North Card Room

Louis M. Orr, Chairman
Samuel M. Day
Russell B. Carson
Donald W. Smith
George W. Morse

4. LEGISLATION
South Card Room

Edward R. Annis, Chairman
H. Phillip Hampton
Francis T. Holland
Joseph J. Lowenthal
V. Marklin Johnson

PATIO PARTY

Tuesday, 7:00 p.m.

HOTEL FONTAINEBLEAU — PAVILLON AREA

The Patio Party will immediately precede the Annual Dinner and is to be held in the Pavillon Area, Hotel Fontainebleau.

Tickets for the Patio Party will be on sale at the Registration Desk ($3.50 per person). Informal entertainment appropriate to the occasion is being arranged by the local committee.

ASSOCIATION DINNER

Tuesday, 8:00 p.m.

HOTEL FONTAINEBLEAU — PAVILLON

Master of Ceremonies, H. Phillip Hampton, Tampa

Tickets ($9.00 per person) will be available at the Registration Desk in the Foyer, just beyond the Scientific Exhibits.

WEDNESDAY

May 16

BOARD OF PAST PRESIDENTS

Wednesday, 8:00 a.m.

HOTEL FONTAINEBLEAU — ROSEWOOD ROOM

Orion O. Feaster, *Chairman*
Duncan T. McEwan, *Secretary*
Breakfast

Election of a Chairman and Secretary
(According to precedence, Edward Jelks will succeed the present chairman and John D. Milton, the present secretary.)

SECOND MEETING HOUSE OF DELEGATES

Wednesday, 10:00 a.m.

HOTEL FONTAINEBLEAU — LA RONDE ROOM

Delegates sign official attendance cards at 10:00 a.m. at the table of Credentials Committee, Ralph W. Jack, Chairman, William C. Roberts and Jere W. Annis, located at the entrance to the La Ronde Room.

No Alternates are to be seated for Delegates attending yesterday's meeting.

President Milton in the Chair, 10:30 a.m.

Number of eligible Delegates present. Report by Ralph W. Jack, Chairman, Credentials Committee.

Recommendations of Reference Committees:
No. 1. Health and Education
Warren W. Quillian, Chairman

Memorial Service—Msgr. William Barry

No. 2. Public Policy
Francis H. Langley, Chairman

No. 3. Finance and Administration
Louis M. Orr, Chairman

Other unfinished business

Election of Association Officers, 12:00 noon

President-elect

First Vice President

Second Vice President

Third Vice President

Secretary-Treasurer

Editor of The Journal

Dr. Francis H. Langley escorted to the Chair as new President

Presentation of Personal Gavel to Dr. Langley

Presentation of Past President's Button and Certificate of Honor to Dr. John D. Milton by Dr. Francis H. Langley, President

Adjournment

TECHNICAL EXHIBITS

Technical exhibits will be located in the Grand Ballroom of the Hotel Fontainebleau. They have a real scientific value, and physicians who wish to keep abreast of the times and be familiar with the latest development in drugs and medical appliances should spend some time with these exhibits; a surprising amount of useful information can be procured in this way.

Many exhibitors make no attempt to sell, the representatives of the firms being there primarily to give the latest information regarding their products. Those who have items for sale will gladly give information whether there is a purchase or not. Be sure to register your name with the various representatives who are exhibiting.

The following firms have arranged for exhibits at the Miami Beach meeting:

Exhibitor	Booth
Abbott Laboratories	63
A. S. Aloe Company	71-72
Amedic Surgical Company	41
American Ferment Co., Inc.	47
Ames Company, Inc.	34
Anderson Surgical Supply Co.	4
Audio-Digest Foundation	22
Ayerst Laboratories	42
Bilhuber-Knoll Corporation	66
Brayten Pharmaceutical Co.	74
Broward Surgical Supply Company	36
Burroughs Wellcome & Co. (U.S.A.) Inc.	62
Ciba Pharmaceutical Products, Inc.	5
The Coca-Cola Company	17-18
Continental X-Ray Corporation and Standard X-Ray Company	16
The Doho Chemical Corporation	69
Dome Chemicals, Inc.	39
Drug Specialties, Inc.	12
Eaton Laboratories, Inc.	40
Encyclopaedia Britannica, Inc.	79
Encyclopedia Americana	77
Executone, Inc.	24
C. B. Fleet Company, Inc.	44
Florida Brace Corporation	20
Florida Physician's Supply	8
General Electric Company, X-Ray Dept.	50
Gerber Products Company	73
Otis E. Glidden & Company, Inc.	9
Gray Pharaceutical Co., Inc.	10
Guild of Prescription Opticians of Florida	28
J. E. Hanger Incorporated	82
Hart Drug Corporation	80
Charles C. Haskell & Co., Inc.	83
Hoffmann-LaRoche, Inc.	33
Holland-Rantos Company, Inc.	55
Ives-Cameron Company	68
Keleket X-Ray of Florida	58
Lederle Laboratories Div., American Cyanamid Co.	30
Eli Lilly and Company	45
La Femme Products, Inc.	13
Lloyd Brothers, Inc.	67
M & R Laboratories	56
J. A. Majors Company	38
Maltbie Laboratories Div., Wallace & Tiernan, Inc.	75
The S. E. Massengill Co.	21
Mead Johnson & Company	29
The Medical Protective Company	6
Medical Supply Company	11
Medical Supply Co. of Jacksonville	81
The Wm. S. Merrell Company	32
The National Drug Co.	35
The Nestle Company	49
Organon, Inc.	37
Ortho Pharmaceutical Corporation	15
Parco Surgical Supplies	64
Parke, Davis & Company	31
Pet Milk Company	2
Pfizer Laboratories	23
Wm. P. Poythress & Co., Incorporated	53
The Purdue Frederick Company	70



The La Ronde Room, Hotel Fontainebleau, where all Scientific Assemblies of the Eighty-Second Annual Convention are to be held

R. J. Reynolds Tobacco Company 14
Riker Laboratories 43
Ritter Company, Inc. 25-26
A. H. Robins Co., Inc. 84
J. B. Roering and Company 85
Sandoz Pharmaceuticals 46
Schering Corporation 86
Julius Schmid, Inc. 76
G. D. Searle & Co. 1
Sharp & Dohme, Inc. 54
Sherman Laboratories 78
Smith, Kline & French Laboratories 48
E. R. Squibb & Sons 57
Surgical Equipment Company 61
Surgical Supply Company 52
Tablerock Laboratories 59
S. J. Tutag & Co., Pharmaceuticals 51
The Upjohn Company 60
VanPelt & Brown, Inc. 65
Walker Laboratories, Inc. 19
Warner-Chilcott Laboratories 7
Westwood Pharmaceuticals, Division of Foster-Milburn Co. 27
White Laboratories, Inc. 3

SCIENTIFIC EXHIBITS

The scientific exhibits will be located in the Foyer and the Mezzanine of the Hotel Fontainebleau. We consider ourselves fortunate to be able to present for your approval the following exhibits:

Foyer

1-2. Resection and Grafting in the Treatment of Occlusive Arterial Diseases, D. Emerick Szilagyi, M.D., Roger F. Smith, M.D., Claiborne P. Shonnard, M.D., John G. Whitcomb, M.D., Detroit, Mich.

3-4. Improved Adrenal Denervation for Essential Hypertension, Sherman A. Eger, M. D., Philadelphia, Pa.

5. Public Relations — Florida Medical Association, Edward Jelks, M.D., Jacksonville

6-7. Physician's Responsibility in Highway Accidents, American Medical Association, Mr. George B. Larson, Chicago

8. Unusual and Interesting Lesions of the Chest, Leffie M. Carlton Jr., M.D., and Richard G. Connar, M.D., Tampa

9-10. Syncardial Therapy, James F. Lyons, M.D., Coral Gables

11. Bureau of Professional Relations, College of Pharmacy, University of Florida, Mr. Charles S. Haupt, Associate Director

12. Public Relations Activities in Dade County, Christian Keedy, M.D., Chairman, Miami

13. Cancer of the Larnyx, J. Brown Farrior, M.D., Tampa

14. Optimal Timing in Elective Pediatric Surgery, H. Clinton Davis, M.D. and Thomas J. Zaydon, M.D., Miami

15. Therapy of Hemangiomas, Wesley W. Wilson, M.D., Tampa

16. Otorhinologic Plastic Surgery, Maurice I. Edelman, M.D., Miami Beach

17. Bronchogenic Carcinoma, Hawley H. Seiler, M.D., Tampa

18. The Management of Facial Lacerations, Bernard L. N. Morgan, M.D., Jacksonville

19. History of Psychiatry and Its Status Today, Samuel G. Hibbs, M.D., Tampa

20. Surgery of the Adrenal Gland, John J. Farrell, Chm., Dept. of Surgery, Univ. of Miami School of Medicine, Coral Gables

21. Medical Aspects of the Adrenal Gland, Ralph Jones Jr., Univ. of Miami School of Medicine, Coral Gables

Mezzanine

S-1-2. Blood Vessel Transplants, Francis N. Cooke, M.D., Miami

S-3. Medical Auxiliary—Many Activities, Woman's Auxiliary to the Florida Medical Association, Mrs. Perry D. Melvin, Miami

S-4. Vaginal Cytology, Florida Cancer Council, Lorenzo L. Parks, M.D., Jacksonville

S-5. Demonstration of Polio Viruses, Florida State Board of Health, Nathan Schneider, Ph.D., Jacksonville

S-6. Cytology and the Early Accidents of Pregnancy, Wayne S. Rogers, M.D., J. Ernest Ayre, M.D., Joseph A. Rudnick, M.D., Hialeah, and Kola Kennedy, Miami

S-7. Florida State Alcoholic Rehabilitation Program, Mr. Barton Johns, Avon Park

S-8. Poison Control Centers, Florida Pediatric Society and Florida Chapter, Amer. Academy of Pediatrics, Robert J. Grayson, M.D., Miami Beach

S-9. Blue Shield of Florida, Russell B. Carson, M.D., Fort Lauderdale

S-10. Symposium Theatre
Organon, Inc., Orange, New Jersey

S-11. Medical Plight of Migrant Labor, Manning J. Rosnick, M.D., Miami, Charles R. Sias, M.D., Orlando, Paul J. Coughlin, M.D., Tallahassee and George W. Karelas, M.D., Newberry.

Each of the technical exhibits contribute to the scientific information available at the convention. Doctor, will you visit each booth and show your appreciation of the exhibitor's fine cooperation and costly outlay?

TWENTY-NINTH ANNUAL MEETING
Woman's Auxiliary
TO THE FLORIDA MEDICAL ASSOCIATION

Hostess Auxiliary
Woman's Auxiliary to the Dade County Medical Association

CONVENTION COMMITTEE CHAIRMEN

Chairman and Co-Chairman	Mrs. Robert F. Mikell Mrs. C. Russell Morgan Jr.
Ticket Committee	Mrs. Matthias P. Meehan
Meeting Committee	Mrs. Donald F. Marion
Decoration Committee	Mrs. Nicholas A. Tierney Mrs. O. Whitmore Burtner
Transportation Committee	Mrs. Edward R. Annis
Exhibit Committee	Mrs. Perry D. Melvin
Hospitality Committee	Mrs. Edward W. Cullipher Mrs. Ralph S. Sappenfield
Golf Tournament Committee	Mrs. R. Spencer Howell

GENERAL INFORMATION

- GENERAL REGISTRATION: will be held along with registration of members of the Florida Medical Association in the Foyer just beyond the Scientific Exhibits, Hotel Fontainebleau, Sunday, Monday, and Tuesday, 8:30 a.m. to 5:30 p.m., Wednesday, 8:30 a.m. to 12:30 p.m.
- REGISTRATION FOR DELEGATES for the Annual Auxiliary Session: Entrance to Civic Room.
- AUXILIARY MEETINGS: All meetings of the Auxiliary will be in the Hotel Fontainebleau, except the Pre-convention Board meeting.
- TICKETS: Annual Auxiliary Luncheon, Fleur de Lis Room: (Location to be announced.)
- PATIO PARTY AND ANNUAL ASSOCIATION DINNER: Tickets may be obtained at the General Registration Desk, in the Foyer just beyond the Scientific Exhibits, Hotel Fontainebleau.
- GOLF TOURNAMENT: Second Golf Tournament for Ladies will be held. See information under General Convention Golf Committee.
- EXHIBIT: Woman's Auxiliary Exhibit on the mezzanine.

PROGRAM

Sunday, May 13
Sovereign Hotel — Card Room (Main Floor)
2:30 p.m.

- PRE-CONVENTION EXECUTIVE BOARD MEETING: 1956-57 State Committee Chairmen invited.
- OUR DISTINGUISHED GUEST: Mrs. Mason G. Lawson, President, Woman's Auxiliary to the American Medical Association.
- PRESIDING: Mrs. Samuel S. Lombardo, President.

Monday, May 14
9:00 a.m.
Hotel Fontainebleau — Civic Room (lower level)

- OPENING SESSION: Annual Meeting, Woman's Auxiliary to the Florida Medical Association.
- CALL TO ORDER: Mrs. Samuel S. Lombardo, President.
- INVOCATION: Dr. Frederick Nelson, Miami Shores Community Church
- PLEDGE OF LOYALTY: To the Woman's Auxiliary to the American Medical Association, Mrs. Herschel G. Cole, State Past President.



Mrs. Samuel S. Lombardo
President, Woman's Auxiliary

I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals.

- ADDRESS OF WELCOME: Mrs. Robert F. Dickey, President, Woman's Auxiliary to the Dade County Medical Association.
- RESPONSE: Mrs. Nelson A. Murray, President, Woman's Auxiliary to the Duval County Medical Society.
- A MESSAGE FROM THE ASSOCIATION: Dr. Francis H. Langley, President-Elect, Florida Medical Association.
- PRESENTATION OF CONVENTION CHAIRMAN: Mrs. Robert F. Mikell, Miami.
 Presentation of committee chairmen on local arrangements.
- ANNOUNCEMENTS
- PRESENTATION OF MRS. MASON G. LAWSON, President, Woman's Auxiliary to the American Medical Association.
- INTRODUCTIONS: Mrs. Samuel S. Lombardo, President.
- REMARKS FROM OUR ADVISORY BOARD: Dr. Wiley M. Sams, Miami.

- ROLL CALL AND REPORT ON NUMBER OF ELIGIBLE DELEGATES PRESENT: Mrs. Leffie M. Carlton Jr., Tampa, Secretary.
- MINUTES OF THE TWENTY-EIGHTH ANNUAL MEETING: Mrs. Leffie M. Carlton Jr.
- CONVENTION RULES OF ORDER: Mrs. C. Russell Morgan Jr., Miami, Parliamentarian.
 1. *Each county auxiliary will be represented by the president and a delegate for every 25 members or major fraction thereof.*
 2. *Officers and delegates are requested to sit in sections provided for them.*
 3. *When addressing the Chair, the member shall announce her name and that of her auxiliary.*
 4. *Resolutions may be considered only when presented by the committee on resolutions after proper processing.*
 5. *All visitors are welcome at the general session and are requested to register.*
 6. *No one delegate may speak more than twice on any one subject and not for more than two minutes at any one time.*
 7. *Oral reports of counties shall be limited to two minutes.*
 a. *Timekeepers shall notify each speaker when time is up.*
 b. *Please hold applause until all reports have been given.*
 c. *Those giving reports please occupy front row of seats until report has been presented.*
 8. *Robert's Rules of Order shall apply in all instances not covered by these special rules.*
- IN MEMORIAM: Mrs. Wendell J. Newcomb, Past President, for Mrs. Paul F. Baranco, President, Woman's Auxiliary to the Escambia County Medical Society.
- GAVEL TO FIRST VICE PRESIDENT: Mrs. Edward W. Cullipher, Miami.
- ADDRESS OF THE PRESIDENT: Mrs. Samuel S. Lombardo.
- COUNTY PRESIDENTS' ORAL PRESENTATIONS OF AUVILIARY ACHIEVEMENTS, DISTRICTS C AND D:
 Broward, Mrs. James M. Weaver
 Dade, Mrs. Raymond L. Evans
 Hillsborough, Mrs. Linus W. Hewit
 Lee-Collier-Charlotte-Hendry, Mrs. Angus D. Grace
 Manatee, Mrs. Richard V. Meaney
 Palm Beach, Mrs. Joseph J. Daversa
 Pinellas, Mrs. Abbott Y. Wilcox Jr.
 Polk, Mrs. Williard E. Manry Jr.
 Sarasota, Mrs. Melvin M. Simmons
 St. Lucie-Okeechobee-
 Martin, Mrs. Laurance D. Van Tilborg
- REPORTS OF STATE OFFICERS, COMMITTEE CHAIRMEN AND COUNTY PRESIDENTS:
 Note: If there is no objection, the reports of State Officers, Chairmen and County Presidents will be accepted as printed and placed on file, except for such reports that require action of the convention.
- UNFINISHED BUSINESS
- NEW BUSINESS
- ELECTION OF 1957 NOMINATING COMMITTEE
- ELECTION OF THE DELEGATES TO THE NATIONAL CONVENTION
- REPORTS OF THE COURTESY RESOLUTIONS COMMITTEE: Mrs. Laurance D. Van Tilborg, Fort Pierce, Chairman.
- REPORT OF REGISTRATION: Mrs. Robert F. Mikell, Miami, Convention Chairman.
- COUNTY PRESIDENTS' ORAL PRESENTATIONS OF AUXILIARY ACHIEVEMENTS, DISTRICTS A AND B:
 Alachua, Mrs. G. Leonard Emmel
 Brevard, Mrs. Charles E. Russell
 Duval, Mrs. Nelson A. Murray
 Escambia, Mrs. Paul F. Baranco
 Jackson-Calhoun, Mrs. William R. Wandeck
 Lake-Sumter, Mrs. Lawton F. Douglass
 Leon-Gadsden-Liberty-Wakulla-
 Jefferson, Mrs. Benjamin A. Wilkinson
 Marion-Levy, Mrs. John P. Moore
 Orange, Mrs. W. Dean Steward
 St. Johns-Flagler, Mrs. Donald T. Rankin
 Seminole, Mrs. Charles L. Park Sr.
 Volusia, Mrs. Joel Mendelson
- REPORT OF 1956 NOMINATING COMMITTEE: Mrs. Burns A. Dobbins Jr., Fort Lauderdale, Chairman.
- ELECTION OF AUXILIARY OFFICERS:
 President-Elect
 First Vice President
 Second Vice President
 Third Vice President
 Fourth Vice President
 Secretary
 Treasurer
- INSTALLATION OF OFFICERS: Mrs. Mason G. Lawson, President, Woman's Auxiliary to American Medical Assn.
- PRESENTATION OF PAST PRESIDENT'S PIN: To Mrs. Samuel S. Lombardo, Jacksonville, by Mrs. Gordon F. Ira, Jacksonville, Past President.
- ESCORTING MRS. SCOTTIE J. WILSON TO THE CHAIR AS NEW PRESIDENT: Mrs. Norris M. Beasley and Mrs. Donald H. Gahagen, Fort Lauderdale.
- PRESENTATION OF THE GAVEL: To the new President by Mrs. Samuel S. Lombardo.
- INAUGURAL ADDRESS: Mrs. Scottie J. Wilson, President.
- ADJOURNMENT

1:00 p.m.

- ANNUAL AUXILIARY LUNCHEON: Hotel Fontainebleau, Fleur de Lis Room. Honoring Mrs. Mason G. Lawson, President, Woman's Auxiliary to American Medical Association, and Presidents, Florida Medical Auxiliaries.
 GUEST SPEAKER: Mrs. Mason G. Lawson, President, Woman's Auxiliary to the American Medical Association, "Active Leadership in Community Health."

Tuesday, May 15

9:30 a.m.

HOTEL FONTAINEBLEAU — ROSEWOOD ROOM

- POST-CONVENTION BOARD MEETING: Mrs. Scottie J. Wilson, Presiding. Members of the Board are State Officers, Committee Chairmen and County Presidents. County Presidents-Elect and Members at Large are especially invited to attend.

AD HOC COMMITTEE CHAIRMEN

Courtesy Resolutions	Mrs. Laurance D. Van Tilborg, Fort Pierce
Election	Mrs. Donald T. Rankin, St. Augustine
Memorial	Mrs. Paul F. Baranco, Pensacola
Reading	Mrs. Richard V. Meaney, Palmetto
Timekeepers	Mrs. Terry Bird, Sanford Mrs. Roger E. Phillips, Orlando

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Co-Chairmen	Mrs. Robert F. Mikell Mrs. C. Russell Morgan Jr.
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Mrs. Scottie J. Wilson
President-Elect, Woman's Auxiliary



Mrs. Mason G. Lawson, President,
Woman's Auxiliary to the American Medical Association

Decorations	Mrs. Nicholas A. Tierney
	Mrs. O. Whitmore Burtner
	Mrs. Herman Boughton
	Mrs. Richard M. Fleming
Golf	Mrs. R. Spencer Howell
	Mrs. Alfred G. Levin
	Mrs. James H. Putman
	Mrs. John R. Richardson
	Mrs. Julian A. Rickles
	Mrs. Nelson Zivitz
Exhibit	Mrs. Perry D. Melvin
	Mrs. Milton M. Coplan
	Mrs. Willard L. Fitzgerald
	Mrs. Frank W. Hewlett
	Mrs. Frazier J. Payton
	Mrs. Oden A. Schaeffer
Meeting	Mrs. Donald F. Marion
	Mrs. Francis N. Cooke
	Mrs. Robert P. Keiser
Press and Publicity	Mrs. John W. Dix
Registration	Mrs. William P. Smith
	Mrs. Henry H. Bryant III
	Mrs. L. Washington Dowlen
	Mrs. Otto S. Dowlen
	Mrs. Richard C. Forman
	Mrs. Edward F. Fox
Tickets	Mrs. Matthias P. Meehan
	Mrs. C. Harold Edmunds
	Mrs. Maurice P. Cooper
	Mrs. Chaffee A. Scarborough
Transportation	Mrs. Edward R. Annis
	Mrs. Arthur W. Wood Jr.

The Technical Exhibit

One feature which adds materially to the success of the annual meeting is the technical exhibits. Each firm represented features products of particular interest to the physician. Make a special effort to visit each booth at some time during the convention and register your name with the attending representative.

The Technical Exhibit Hall will be open Sunday, Monday and Tuesday, 8:30 a.m. to 5:30 p m., and on Wednesday from 8:30 a.m. to 12:30 p.m. The booths may be dismantled after 12:30 p.m.

G. D. SEARLE & CO. — 1

You are cordially invited to visit the Searle booth where our representative will be happy to answer any questions regarding Searle Products of Research.

Featured will be Mictine, the new safe, non-mercurial oral diuretic; Vallestril, the new synthetic estrogen with extremely low incidence of side reactions; Banthine and Pro-Banthine, the standards in anti-cholinergic therapy; and Dramamine, for the prevention and treatment of motion sickness and other nauseas.

PET MILK CO. — 2

We will be pleased to have you stop and discuss the variety of time-saving material available to busy physicians. Our representatives will be on hand to discuss the merits of "Pet" Evaporated Milk for infant feeding and INSTANT "Pet" Nonfat Dry Milk for special diets. A miniature "Pet" Evaporated Milk can will be given to all visitors.

WHITE LABORATORIES, INC. — 3

ANDERSON SURGICAL SUPPLY CO. — 4

You are cordially invited to stop by the Anderson booth and inspect the "Oro Forced Food Pump" which will be featured.

CIBA PHARMACEUTICAL PRODUCTS — 5

MEDICAL PROTECTIVE CO. — 6

An unparalleled record of successfully fighting malpractice charges against doctors since 1899 distinguishes The Medical Protective Company from all others. Year in and year out 99.94 percent of its policy holders have been completely covered under $2,500. Exclusive application to the professional liability field makes this unique record possible.

WARNER-CHILCOTT LABORATORIES — 7

FLORIDA PHYSICIANS SUPPLY — 8

We are exclusive distributors of Mattern X-Ray, Jones Basal Metabolism equipment and Beck-Lee Electrocardiograph. We also handle the Raytheon Microtherm, R.A. Fischer physiotherapy equipment, Dallons ultrasonic and Shampaine, Allison and Brooklyn furniture.

In addition to the above, we carry a complete line of surgical supplies and pharmaceuticals.

OTIS E. GLIDDEN & CO. — 9

New products, BSP Liquid for bed sore prevention, and ZYLAX for fast, gentle laxation, are being introduced to you here. ZYMENOL and ZYMELOSE are on exhibit, too. Samples are available at our booth or our representative, Eric H. Ericson, will arrange to send the desired material to you.

GRAY PHARMACEUTICAL CO., INC. — 10

The Gray Pharmaceutical Co., Inc., is pleased to present the following products: Lysidox—Contains the essential amino acid L-Lysine, pyridoxine, and "Graylac", a defated milk base. Lysidox transforms a low quality protein diet into a high quality protein diet. Lysidox is recommended for toast eating, geriatric patients suffering from lassitude, chronic fatigue, and low grade anemia. L-Glutavite—Is a palatable mixture of therapeutic dosages, of monosodium L-glutamate and niacin with specific vitamins and minerals concerned with the optional nutritional and blood supply of the brain. It is indicated for elderly patients who suffer from cerebral symptomatology.

MEDICAL SUPPLY CO. — 11

DRUG SPECIALTIES, INC.—12

Drug Specialties, Inc. will feature Nicozol as a cerebral tonic and stimulant in the treatment of the aged.

LaFEMME PRODUCTS, INC. — 13

You are cordially invited to visit the LaFemme booth during the Association's Annual Meeting at the Hotel Fontainbleau. Representatives will be on hand to greet you and answer any questions you may have.

R. J. REYNOLDS TOBACCO CO. — 14

Welcome to the R. J. Reynolds Tobacco Company exhibit! You are cordially invited to receive a cigarette case (monogrammed with your initials) containing your choice of CAMEL, CAVALIER King Size, or WINSTON, the distinctive new king size filter cigarette.

ORTHO PHARMACEUTICAL CORP.—15

CONTINENTAL X-RAY CORP. — 16

THE COCA-COLA CO. — 17-18

Ice-cold Coca-Cola served through the courtesy and cooperation of the Miami Coca-Cola Bottling Company and The Coca-Cola Company.

WALKER LABORATORIES, INC. — 19

PRECALCIN, PRECALCIN LACTATE, BACIMYCIN OINTMENT, ADCETS and HEDULIN will be displayed at the exhibit. PRECALCIN LACTATE is the phosphorus-free comprehensive multi-vitamin-mineral formula with "built-in" antianemia factors for use during pregnancy. HEDULIN is the relatively safe oral anticoagulant described in recent papers and complete reprint portfolios will be available to all registered physicians.

FLORIDA BRACE CORP. — 20

Florida Brace Corporation will exhibit THE JEWETT BRACE, for hyperextension of the spine in the treatment of spinal conditions requiring positive hyperextension such as simple compression fractures, Osteoporosis, Adolescent Epiphysitis, and Marie Struempell's Disease. They are also introducing the MYO CERVICAL COLLAR, a rigid modification of the Thomas Collar, with the unusual feature of adjustability of height and degree of hyperextension.

THE S. E. MASSENGILL CO. — 21

AUDIO-DIGEST FOUNDATION — 22

Audio-Digest Foundation—a subsidiary of the California Medical Association—gives the busy physician an effortless tour through the best of current medical literature each week. This medical tape-recorded "newscast" —compiled and reviewed by a professional Board of Editors—may be heard in the physician's automobile, home or office. The Foundation also offers medical lectures by nationally-recognized authorities.

PFIZER LABORATORIES — 23

The Pfizer exhibit again will be in the spotlight with its new and original concept of anti-stress, anti-infective therapy—TETRACYN S.F. and TERRAMYCIN S.F. (Stress Fortified). Also, the complete line of Pfizer antibiotics and STERAJECT as well as the new specialties, BONAMINE, TYZINE, TOCLASE and the complete line of steriod hormones including CORTRIL and the latest corticosteriod STERANE (brand of prednisolone).

EXECUTONE, INC. — 24

Executone communication systems especially designed for doctors and clinics will again be shown in the Technical Exhibit Hall at the Miami convention. Over two hundred doctors' offices and clinics in the state are equipped with Executone. Many doctors have found Executone equipment to be of help to them in expediting the flow of patients and enabling the doctor to give better patient care, yet see more patients. Any doctor moving, building, or contemplating building, should see this exhibit and the new equipment available.

RITTER CO., INC. — 25-26

WESTWOOD PHARMACEUTICALS — 27

GUILD OF PRESCRIPTION OPTICIANS OF FLORIDA — 28

MEAD JOHNSON & CO. — 29

The new Deca vitamin family for the vital first decade of life will be exhibited by Mead Johnson & Company in booth 29. Included in the new Deca family of vitamin specialties are: Deca-Vi-Sol, for dropper dosage, a fruit flavored solution for infants and toddlers; Deca-Mulcin, for teaspoon dosage, a pleasantly-flavored liquid for preschool children of 2 to 6 years; and Deca-Vi-Caps, small, easily-swallowed capsules, for school-agers of 6 to 10 years. All three Deca vitamin specialties supply 10 nutritionally significant vitamins including A, C, and D, plus 7 important B vitamins.

LEDERLE LABORATORIES DIVISION — 30

You are cordially invited to visit the Lederle booth where our medical representatives will be in attendance to provide the latest information and literature available on our line.

Featured will be Achromycin, Incremin, Diamox, Vitamins, Pathilon, Varidase and many other of our dependable quality products.

PARKE, DAVIS & CO. — 31

Medical service members of our staff will be in attendance at our exhibit for consultation and discussion of various products of particular interest to members of the Association. Important specialties, such as Penicillin S-R, Benadryl, Choloromycetin, Ambodryl, Dilantin Suspension, Vitamins, Oxycel, Milontin, Amphedase, Thromhin Topical, etc., will he featured. You are cordially invited to visit our exhibit.

THE WILLIAM S. MERRELL CO. — 32

TACE, the unique non-steroid developed by Merrell, offers a new approach to the treatment of the menopause.

TACE is temporarily stored in body fat, and released over an extended period of time. One course of TACE therapy is generally all that is required to ease many patients into the symptom free postmenopausal period. Symptom relief is excellent, and side effects are virtually absent.

Merrell professional service representatives will be present to answer any questions you may have concerning this new and distinctive estrogen. They will be happy to discuss other Merrell specialties as well.

HOFFMANN-LaROCHE, INC. — 33

NOLUDAR is a new, non-barbiturate hypnotic which provides effective relief of insomnia and tension states. NOLUDAR is so well tolerated that side effects such as nausea, vomiting, and dizziness, are rarely, if ever experienced with therapeutic doses. NOLUDAR is available in scored tablets of two strengths, 50 mg and 200 mg, and in a cordial-flavored elixir, 50 mg per teaspoonful.

AMES COMPANY, INC. — 34

AMINET, a combination of Aminophylline and Pentobarbital in a newly developed nonreactive base which melts readily at body temperatures and quickly releases the active ingredients for rapid absorption. Highly effective in relieving the paroxysms of bronchial asthma; especially valuable with epinephrine-fast patients. Also of value in cardiac asthma, congestive failure, and as a diuretic and myocardial stimulant.

DECHOLIN and DECHOLIN SODIUM, dehydrocholeretics of choice, will also be on display.

THE NATIONAL DRUG CO. — 35

BROWARD SURGICAL SUPPLY CO. — 36

ORGANON, INC. — 37

Physicians are cordially invited to visit the Organon booth where will be exhibited two products of great interest to the medical profession, Cortrophin-Zinc and Wigraine. Cortrophin-Zinc is the newest form of ACTH therapy: a long-acting aqueous suspension which provides the complete physiologic action of ACTH, enhanced, prolonged, and with convenience of administration never before possible in an ACTH preparation. It requires no heating prior to injecting and flows freely through a #24 gauge hypodermic needle and insulin syringe. Each cc (40 U.S.P. units) provides therapeutic ACTH activity for 1-3 days.

Wigraine is Organon's complete migraine therapy preparation. It contains ingred'ents which treat effectively the entire migraine syndrome: ergotamine tartrate and caffeine for head pain; belladonna alkaloids for nausea and vomiting; and acetophenetidin for residual occipital muscle pain. These ingredients are contained in a rapidly disintegrating tablet which aborts the migraine attack quickly.

Literature and samples will be available at the booth.

J. A. MAJORS CO. — 38

Latest publications of W. B. Saunders Company will be on display for your examination. Some of the newer titles are as follows: New sixth edition Christopher "Textbook of Surgery," New second edition Wolff "Electrocardiography," New second edition Sodeman "Pathologic Physiology," Gross "Cardiac Therapy," Pillsbury "Dermatology."

DOME CHEMICALS, INC. — 39

Dome Chemicals, Inc., presents: DOMEBORO, buffered 1:20 aluminum acetate solution (pH 4.2); CORT-DOME CREME and LOTION (pH 4.6), the most effective hydrocortisone, micronized hydrocortisone alcohol incorporat d in the exclusive Acid Mantle Creme (pH 4.2) and Lotion (pH 4.5) base, respectively; and VI-DOM-A BUCCAL TABLETS, containing 75,000 and 150,000 USP units synthetic Vitamin A each in small candy-like troche, for generalized systemic uses (through buccal absorption) such as Acne, Xerophthalmia, Senile Vaginitis.

EATON LABORATORIES, INC. — 40

A new specific for Trichomonas vaginalis is now available for treating trichomonal vaginitis. This is Tricofuron (T.M.) Vaginal Suppositories and Powder.

Tricofuron affords relief of symptoms within a few days, and cures the majority of cases within one menstrual cycle.

The latest clinical data on Furadantin(R) in treating urinary tract infections and prostatitis will be available.

AMEDIC SURGICAL CO. — 41

AYERST LABORATORIES — 42

Physicians are invited to visit booth No. Forty-two where Ayerst representatives will be on hand to welcome them and discuss any Ayerst specialties of interest to them.

RIKER LABORATORIES — 43

C. B. FLEET CO. — 44

During the past fifty years PHOSPHO-SODA (Fleet) has been a symbol of elegance in sodium phosphate medication. FLEET ENEMA DISPOSABLE UNIT — an enema solution of Phospho-Soda (Fleet) — is a worthy companion product. The single use unit simplifies and assures satisfying preparation for proctoscopy and as a routine enema it is a boon to the hospitalized patient.

ELI LILLY & CO. — 45

You are cordially invited to visit the Lilly exhibit located in space number 45. The display will contain information on recent therapeutic developments. Lilly sales people will be in attendance. They welcome your questions about Lilly products.

(Continued on page 872)



An aerial view of Miami Beach showing the Hotel Fontainebleau in the foreground.


TRANS WORLD AIRLINES
TWA



ACHROMYCIN*

Tetracycline *Lederle*

in the treatment of

respiratory infections

January and his associates[1] have written on the use of tetracycline (ACHROMYCIN) to treat 118 patients having various infections, most of them respiratory, including acute pharyngitis and tonsillitis, otitis media, sinusitis, acute and chronic bronchitis, asthmatic bronchitis, bronchiectasis, bronchial pneumonia, and lobar pneumonia. Response was judged good or satisfactory in more than 84% of the total cases.

Each month there are more and more reports like this in the literature, documenting the great worth and versatility of ACHROMYCIN. This antibiotic is unsurpassed in range of effectiveness. It provides rapid penetration, prompt control. Side effects, if any, are usually negligible.

No matter what your field or specialty, ACHROMYCIN can be of service to you. For your convenience and the patient's comfort, Lederle offers a *full* line of dosage forms, including

ACHROMYCIN SF

ACHROMYCIN with STRESS FORMULA VITAMINS. Attacks the infection—defends the patient—hastens normal recovery. For severe or prolonged illness. Stress formula as suggested by the National Research Council. Offered in Capsules of 250 mg. and in an Oral Suspension, 125 mg. per 5 cc. teaspoonful.

dry-filled sealed capsules

For more rapid and complete absorption. Offered only by Lederle!

[1]January, H. L. et al: Clinical experience with tetracycline. *Antibiotics Annual* 1954-55, p. 625.

Lederle

LEDERLE LABORATORIES DIVISION

AMERICAN CYANAMID COMPANY

PEARL RIVER, NEW YORK

*REG. U. S. PAT. OFF.

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Eighty-Second Annual Meeting

Miami Beach will be host to the Florida Medical Association this year for its Eighty-Second Annual Meeting. Although the state convention has been held 11 times in the Greater Miami area, four times in Miami and seven times in Hollywood, never before has Miami Beach been chosen. The opening session is scheduled for Monday morning, May 14, and the meeting will continue through Wednesday noon, May 16. The Fontainebleau Hotel will be the headquarters. Both the place and the time, which is several weeks later than formerly, promise to be particularly pleasing to the membership and should attract an unusually large attendance. The program is published in detail in this issue of The Journal.

Every effort has been made to arrange an excellent scientific program having wide appeal, to be presented at the three scientific assemblies on Monday morning and afternoon and Tuesday afternoon. Included among the 18 essayists are three eminent guest lecturers, Dr. Shields Warren, of Boston, Dr. James J. Callahan, of Chicago, and Dr. Lauren H. Smith, of Philadelphia.

The first meeting of the House of Delegates will take place on Tuesday morning. At that time Dr. John D. Milton, President, will deliver his address. A coterie of distinguished leaders of the American Medical Association will attend the meeting. The President's guest speaker is Dr. John W. Cline, of San Francisco, a past president of that organization, who will speak on "Biliary Tract Surgery" at the second general session on Tuesday morning. Dr. Elmer Hess, of Erie, Pa., President, and Dr. Dwight H. Murray, of Napa, Calif., President-Elect of the American Medical Association, will be recognized for brief remarks, Dr. Hess on Monday, May 14, at the first general session and Dr. Murray on Tuesday, May 15, at the second general session.

The Grand Ball Room will house the commercial exhibits, and the scientific exhibits will be prominently displayed in the adjoining foyer and on the mezzanine. These many exhibits will offer valuable information to all members of the Association, whatever their particular interests. They merit careful inspection.

On Tuesday night the Patio Party will be held in the Pavillon area and will be followed by the annual Association dinner in the Pavillon, the highlight among the social events. There will also be the usual alumni and fraternity suppers at specified times.

There are 17 specialty groups whose custom it is to meet in conjunction with the Association's convention. They have scheduled their meetings on the Saturday and Sunday immediately preceding the opening of the convention.

The annual pre-legislative joint meeting of the Board of Governors, members of the House of Delegates, Bureau of Public Relations and Committee on Legislation and Public Policy is scheduled for the North Card Room at 8 p.m., Monday, May 14.

Regarded as the largest luxury resort of its kind in existence, the Hotel Fontainebleau is situated on the ocean at Forty-Fourth Street, the site of the world-renowned Firestone Estate. Its attractions include superbly appointed guest rooms, an extensive cabana area and two swimming pools, a large yacht basin, tennis courts, a putting green, a golf driving range, and a shuffleboard court. In the beautifully landscaped areas are faithful reproductions of the formal gardens of Fontainebleau and Versailles in France. Priceless sculptures and antiques, imported from France, adorn the palatial main lobby. The Association meetings will be held in La Ronde Club, a unique round room which boasts a hydraulic stage, special lighting, a bandshell, and not a single pillar to obstruct the view.

Floridians know well the attractions of Miami Beach, the fabulous year-round playground of the Americas. They naturally think and speak of it in extravagant terms for it is in the center of all that is gay and exciting and interesting in Southeastern Florida. Its golden shore offers ample opportunity for the enjoyment of favorite sports and a wide variety of day and night entertainment. This fisherman's paradise boasts four golf courses, on one of which, the Bayshore Golf Club, the Association's golf tournament will be held.

In the heart of America's tropics, completely surrounded by water and only three miles from the Gulf Stream, this enchanting city is a mere one mile wide at its widest point. It boasts America's finest year-round climate, the average winter and summer temperatures varying only 13 degrees. So mid-May should be ideal. Come to glamorous Miami Beach, where fun is always in season, to enjoy the stimulus of good fellowship and an excellent medical meeting, and also an unexcelled opportunity to rest and relax.

A Guest Who Practices What He Preaches

Among the distinguished guests expected at the annual convention of the Association in Miami Beach next month is Dr. Dwight H. Murray, President-Elect of the American Medical Association. This gifted California general practitioner gave convincing proof recently that he knows his public relations, an asset by no means negligible for the task ahead.

In an address presented before the Eighth National Medical Public Relations Conference which preceded the A. M. A. clinical session in Boston last December, he said of his profession: "We should work even harder than before to further improve our relationship with the press. . . . We should learn to tell our story in such a way that it is always newsworthy." So newsworthy was his speech that the Associated Press carried a lengthy abstract of it coast-to-coast and newspapers throughout the country gave it a considerable amount of space.

Because it discussed primarily the present day relationship between physicians and the public, Dr. Murray's speech was tailor-made for newspapers. Likewise, it appears to be tailor-made for medical journals. The following excerpts show why it is newsworthy for every member of the medical profession:

"I think," said this family doctor, "that the key to the way people outside the medical profession regard us is the manner in which we regard them. . . . No one is going to give one hoot about the problems of the medical profession if we sit on our pedestals waiting for others to come to us.

"Our training may have bred in us the habit of individual responsibility, but we are not the only persons with such training. There are millions of other individuals in this country who are just as interested in the promulgation of our free enterprise system as we are. Many of them feel even more strongly about the threat of socialism than we do. Whatever political battles the medical profession may have won in the past were not won by the physicians alone. Victory was achieved only through the support of millions of other voters.

"We talk much about how good medical public relations begins in each doctor's office. Unfortunately, that's where most of it also ends. Outside of his office, many a doctor shields himself from contact with other citizens like a clois-

tered nun. He uses his wife and children as a buffer between himself and his neighbors. . . .

"Is it any wonder, then, that we get the feeling so often that nobody understands us and our problems? How can they? We never give other people a chance to know us. Do we understand our neighbors and the rest of the citizens of our respective communities? Hardly. We know their appendices and their kidneys and their livers and their tonsils, but we don't know what makes them tick as fellow human beings who live and eat and work and play just as we do. If we would but stop and look around, we would learn that we have many things in common with our neighbors, and they would be very willing to help us with our problems if we would help them with theirs."

Welcome to Florida, Dr. Murray. This lesson in human relationships augurs well for strong leadership right from the grass roots in medicine's highest post, which you assume in June. The members of this Association welcome the opportunity to know you.

Dr. Hampton Testifies on Social Security Bill

Dr. H. Phillip Hampton, of Tampa, Chairman of the Committee on Legislation and Public Policy of the Florida Medical Association, was one of 15 practicing physicians from all sections of the nation who went to Washington to testify on February 22 and 23 in opposition to the disability section of the social security bill, H.R. 7225, which at this writing is still before the Senate Finance Committee. In presenting his testimony Dr. Hampton ably represented the Florida Medical Association at the request of the American Medical Association.

Speaking out of broad experience as a physician in military and civilian life confronted with the task of determining permanent and total disability, Dr. Hampton observed at the outset: ". . . the state of permanent and total disability, although ominous and final in its connotation, defies definition and, regardless of the medically determined infirmity, the degree of real disability is a matter of will and motivation which is difficult to represent statistically." He cited a series of several hundred cases in which he had served as an examining officer for an Army retiring board during part of World War II. His analysis of this series disclosed that the most frequent cause of disability was psychoneurosis; this was the retiring diagnosis in approximately 50 per cent of 447 officers. Yet many officers retired for physical disability were capable and willing to continue military service, but their retirement was required by regulation. He observed a similar pattern of disability diagnoses among hundreds of enlisted men in the Army. Also, in civilian practice wide experience with workmen's compensation claimants and recipients of public welfare being considered for rehabilitation led him to like observations.

"As a result of these experiences," said Dr. Hampton, "it is my opinion that no one is more disabled for service than he who does not wish to serve, and serious physical handicap need not disable a person determined to serve. It is impossible by regulation adequately to define disability and to prevent flagrant abuse of disability benefits."

Remarking upon a fundamental fact of human behavior that reward for illness aggravates and perpetuates disability and dependency, Dr. Hampton continued, "There is no more pitiful, useless, and unhappy person than one who has given up his work and opportunities in life in order to justify drawing a small disability pension. . . . To provide cash payments for disability under the Social Security laws would create a national welfare program impossible to regulate, incalculable in cost which would markedly increase in times of unemployment, and insidiously destructive of our most vital national resource — manpower initiative. . . .

"Cash disability payments would not accomplish the desired benevolent end but, on the contrary, would foster deceit, deter rehabilitation, and confound administration of practical constructive aid to the disabled. In addition, cash disability payments would tend to addict the recipient to dependency on the state and thus destroy his freedom. . . . We must find some other way to aid the disabled so that they may be encouraged and enabled to participate in worthwhile endeavors. . . .

"If democracy is to survive, we must intelligently use our resources to relieve mass misery but yet preserve the initiative and integrity of its free individuals. The amendments to the social security laws proposed in H.R.7225 should have a careful analysis of their survival value for our democratic nation in a world where strong forces are seeking to destroy us."

County Medical Societies Expand Activities

During the last two years county medical societies throughout the nation have been busier than ever before. Activities sponsored ran the gamut from control of alcoholism and detection of venereal disease to such community projects as Little League baseball. A growing awareness of the need for more participation in community affairs was manifest in all societies, both large and small.

A recent nationwide survey by the Council on Medical Service of the American Medical Association brought responses from nearly 64 per cent of the county medical societies in the United States and its territories. Questionnaires were sent to 1,931 societies, asking about their professional, educational and community programs, and replies were received from 1,225, representing more than 130,000 physicians.

Over 95 per cent of these societies meet regularly, although an increase in the number of specialty societies and postgraduate meetings, the demand for more hospital staff conferences, and new technics in medical education have tended to minimize the importance of the county society meetings. Some of the larger societies meet bimonthly while the smallest ones may meet only semiannually or annually, but more than two thirds favor the monthly meeting. An increasingly important meeting topic is the socioeconomic aspects of medicine, some societies devoting from a fourth to a half of their meeting time to this subject. Particularly notable was an increase in attendance in the larger societies, although average attendance reached its highest percentage in the smaller societies.

The activities of the societies are handled mostly by committees, the size of the society determining largely the extent of its activities. A public relations committee was the one most frequently reported. Since this field covers a broad area and presents a constant challenge to the medical profession, it is not surprising that 764 of the 1,225 societies reporting had such a committee. Included in this number were all 89 of the societies with more than 300 members and 95 per cent of those with more than 100 members. Only half of the societies with fewer than 100 members reported a public relations committee, although it was the committee most frequently noted among them. Organization since 1953 of 225 of the 704 grievance committees reported illustrates their growing importance. The number of emergency call systems grew from 60 in 1948 to 710 in 1954. Other committees frequently reported included: emergency call, 710; civil defense, 600; ethics, 526; public health, 550; school health, 379; liaison with voluntary health organizations, 343; telephone answering service, 335; hospital relations, 334; mental health, 225; graduate education, 182; collection bureau, 153; and physician assistance programs, 147.

It is particularly noteworthy that some societies are taking cognizance of two pressing problems confronting the medical profession today — the treatment of the elderly patient and the care of the chronically ill. The increasing magnitude of these problems becomes apparent when one realizes that during the last half century the number of persons 65 and older in the population has quadrupled while the general population has only doubled, and that one of six persons eventually will fall into the category of the chronically ill. The elderly patients of course are likely victims of chronic disease. So it is heartening that 84, or about 7 per cent, of the societies surveyed have established geriatrics committees. Seventy-four reported committees on the care of the chronically ill.

Fortunately, the need for standing legislative committees is being recognized more and more. Health legislation measures originating in all units of government have in recent years had increasing impact on the profession. This survey revealed that 621 county societies have realized that it is necessary to examine and discuss the import of proposed legislation and have set up standing legislative committees for this purpose.

In this survey, 207 societies reported publishing bulletins, but only 48 mentioned separate public relations newsletters. Recognizing the growing need to interpret to the layman the medical services they provide, the societies favored the speakers bureau as the most popular outlet, 240 sponsoring this method. Other public education programs were: health forums, 168 societies; state and county fair exhibits, 131; health days, 95; radio programs, 207; and television programs, 116, with others being planned.

Chief among the important facets of the societies' community programs were the indigent care programs, reported by 614 societies. Nearly 400 societies reported that they state publicly that persons who cannot pay need not go without the services of a physician. The use of average

or usual fee schedules was reported by 654 societies, and the use of medical social service workers by 21 societies. Disease control programs included: tuberculosis control, 895 societies; cancer control, 873; blood bank plans, 777; diabetes detection, 737; school health, 489; venereal disease control, 445; rheumatic fever control, 403; health examinations, 368; safety programs, 139; and multiple screening programs, 123.

Society activities and responsibilities have increased to such an extent, especially in the larger groups, that full time executive personnel often is needed to help conduct society business. The number of societies employing lay executives has almost doubled since 1953, increasing from 67 to 121 in 1955. An increasing number of societies maintain their own offices; 73 rent office space and 31 own their buildings. The size of the society influences not only the extent of its activities but also the amount of its dues and special assessments.

This comprehensive survey provides a yardstick by which the component county societies of the Florida Medical Association can measure their activities. Many doubtless will find themselves in the forefront of the over-all picture, and others will be stimulated to greater effort and broader attainments.

Mount Sinai Hospital Postgraduate Seminar Miami Beach, May 17-20, 1956

The Mount Sinai Hospital of Greater Miami Sixth Annual Postgraduate Medical Seminar will be held May 17 through 20 at the Fontainebleau Hotel in Miami Beach. It is scheduled to follow immediately after the annual meeting of the Florida Medical Association and at the same hotel.

The program for the 1956 Seminar is planned to emphasize psychosomatic medicine, recent advances in isotope therapy and diagnosis, antibiotics and chemotherapy.

Dr. Hans Selye of the University of Montreal Faculty of Medicine will be among the distinguished members of the faculty. Others include Dr. Robert Greenblatt of the University of Georgia School of Medicine, Dr. Edward Weiss of Temple University School of Medicine, and Dr. Solomon Silver of New York City.

Dr. Harold Rand, 4300 Alton Road, Miami Beach, is in charge of the meeting.

Graduate Medical Education

Cardiovascular Diseases Seminar Well Attended

A Seminar on Cardiovascular Diseases was presented by the Duval District Heart Association in cooperation with the Division of Postgraduate Education of the College of Medicine of the University of Florida, the Florida Medical Association and the Florida State Board of Health at the Duval Medical Center in Jacksonville on February 23-25. The total enrolment showed a great increase over that of a similar course at this time last year. Physicians from every part of the state were registered.

While medical treatment and medical handling of cardiovascular diseases were reviewed, stress was placed on recent surgical advances emphasizing the indications for and the results of surgery. Dr. Joseph B. Vander Veer, Assistant Professor of Clinical Medicine, University of Pennsylvania School of Medicine, presented the medical phase. Dr. J. Francis Dammann Jr., Associate Professor of Surgery-Cardiology, University of Virginia School of Medicine, discussed congenital heart diseases as well as surgery of the heart. Dr. Robert P. Glover, Director of the Cardiovascular Research Laboratory at Presbyterian Hospital of Philadelphia, discussed remedial surgery for congenital heart diseases and acquired heart diseases in which surgery is indicated.

The outstanding features of the course were the panel discussion on cardiovascular surgery with review of local cases of mitral commissurotomy and the clinical conference with patient demonstration. The interest on the part of those attending the clinical conference was most evident. A similar course is planned at approximately the same time in 1957.

Seminar on Gastroenterology June 21-23

The Division of Postgraduate Education of the College of Medicine of the University of Florida, in cooperation with the Florida Medical Association and the Florida State Board of Health, will present a Seminar on Gastroenterology on June 21-23 at the George Washington Hotel in Jacksonville. This course will be conducted by Dr. David Cayer, Department of Internal Medicine, The Bowman Gray School of Medicine, and Dr. E. Clinton Texter Jr., Northwestern University Medical School. This course is primarily designed for those physicians who are particularly interested in gastrointestinal diseases

and for internists; however, the course is so planned that the general practitioner will profit equally as well from these lectures.

Annual Short Course
June 25-29

This Seminar precedes the Twenty-Fourth Annual Graduate Short Course for doctors of medicine, which is also presented by the Division of Postgraduate Education of the College of Medicine of the University of Florida, the Florida Medical Association and the Florida State Board of Health and will be held at the George Washington Hotel in Jacksonville. The first three days, June 25-27, will be devoted to Medicine, Pediatrics and Psychiatry. The last two days, June 28-29, will be devoted to Surgery and Gynecology. As last year, lectures on obstetrics will not be given.

Dr. Samuel P. Martin, the newly appointed Professor of Medicine of the College of Medicine of the University of Florida, will give the lectures on Medicine. Dr. Howard W. Jones Jr. and Dr. Georgeanna Jones of the Department of Gynecology, The Johns Hopkins University School of Medicine, will deliver the lectures on Gynecology. Other members of the faculty will be announced along with the detailed program in the May issue of The Journal. Tuesday evening, June 26, will be devoted to lectures on the eye. One of these lectures, entitled "The Eye in Geriatrics," will be presented by Dr. Shaler Richardson of Jacksonville.

American Medical Association Annual Meeting in Chicago June 11-15, 1956

Between 12,000 and 15,000 physicians are expected to attend the 105th Annual Meeting of the American Medical Association, which will be held in Chicago. Scheduled for June 11 to 15, it follows by four weeks the state convention of the Florida Medical Association. Plans are nearing completion for nearly five full days of lectures, scientific and technical exhibits, color television and motion picture presentations designed to give physicians a comprehensive short course in postgraduate medical education. Activities will be centered at Navy Pier, Northwestern University, and near north side hotels. The Palmer House will be headquarters for the House of Delegates.

The Technical Exhibits will number some 350, and there will be more than 300 Scientific Exhibits. The exhibits will be on display all week for the benefit of physicians and guests, but probably on Wednesday and Thursday mornings the exhibit hall will be open exclusively for doctors.

The many outstanding scientific features include fracture and fresh pathology exhibits, physical examinations for physicians, exhibit-symposiums on traffic accidents and arthritis and rheumatism, and special exhibits on cardiovascular diseases and pulmonary function tests.

The physicians who are privileged to attend this meeting, whatever their special medical interests, are assured of an unexcelled opportunity to profit by the many lectures and other scientific features setting forth the latest developments in the numerous branches of medicine.

University of Miami School of Medicine Wins Accreditation

Recently, Dr. Jay F. W. Pearson, President of the University of Miami, made an announcement that marks a particularly notable milestone of progress in the history of medical education in Florida. In a public statement he said he had been notified "that the University's School of Medicine, after examination by the survey team of the Liaison Committee on Medical Education and Hospitals and the Association of American Medical Colleges, is now an approved school and its graduates in June will have full rights of licensure and the opportunity to accept internships in approved hospitals."

Accreditation means the attainment of a coveted goal second only in importance to the founding of the School of Medicine. The medical school is now approaching the close of its fourth year of operation and is almost ready to graduate its first doctors. "The University, in June," commented Dr. Pearson, "will confer the first medical doctor's degrees to be awarded in the State of Florida. There is no parallel to our joint achievement, in medical education history elsewhere in the United States. . . . Our University still must build its operating income and endowment and develop special endowment for its School of Medicine. We cannot stand still and we will not stand still."

Congratulations to the University and its School of Medicine on attaining national approval. The success of the school bespeaks co-

operative effort, courageous planning and perseverance. It also gives tangible evidence of the active support and wholehearted cooperation of the Dade County Medical Association, many of whose members have given and are giving unstintingly of their time and talents to make the medical school project the success it is proving to be.

OTHERS ARE SAYING

Estates of Physicians

A recent study made by the Hartford County (Conn.) Medical Society of 144 obituaries of local physicians and probate court cases involving their estates reveals some illuminating — and startling — facts which should make any physician do a bit of checking on his own financial status and on just how fair he is being to his own health.

The study revealed the following, according to an article in the *Hartford Times* and abstracted by the New England Mutual Life Insurance Company's official bulletin, *The Pilot's Log:*

One out of eight of the physicians who died between 1940 and 1953 was in debt at the time of death.

Of the 144 doctor estates studied, one out of three . . . left net assets of less than $10,000.

The Hartford survey disclosed only one extremely wealthy doctor out of the 144 and that $575,915 of his estate was consumed by estate taxes and other settlement expenses.

Only one doctor in eight survived his wife!

The doctors aged 40 to 50 died twice as fast as the general population, and in the 60-70 bracket, the doctors' death rate was 50% higher than the insurance table.

Heart diseases and cerebral hemorrhage were the chief causes of death.

Expenses of settlement of the estates studied ranged from a minimum of 13% to as much as one third.

The age at death of the physicians when compared with life insurance mortality tables showed that there were two vulnerable age periods for medical men — 40 to 50 and 60 to 70.

One out of three physicians left no will.

—New York Medicine
September 20, 1955

CLASSIFIED

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SPECIALIST GROUP FORMING: Large common waiting room. Reception office. Intercom, air-contioned, heat. Very reasonable. Paved parking lot. Also two separate office suites for general practice, each with private waiting room. Medical Dental Arts Bldgs., 1000 S. Federal Highway, Fort Lauderdale. Phone JA 4-3671.

OPHTHALMOLOGIST - OTOLARYNGOLOGIST: Seeks Florida location. Age 36. University trained. Board eligible. Available July 1. Write Leland Glenn, M.D., 4157 Osborne Rd., N. Atlanta 19, Ga.

ARE YOU LOOKING FOR MORE LEISURE TIME AND DIVIDED RESPONSIBILITIES? Diplomate, American Board of Internal Medicine; Fellow, American College of Physicians, and Fellow American College of Cardiology. Fifteen years successful private practice in Cardiology and Internal Medicine, wishes to team up with established man (or group) with similar qualifications, in south Florida, Miami Beach preferred. All replies will be held in strictest confidence. Write 69-175, P.O. Box 1018, Jacksonville, Fla.

GYNECOLOGIST-OBSTETRICIAN: Wishes to live in Florida. American Boards (1955). Broad experience. Would like association with obstetrician or group. Write 69-171, P. O. Box 1018, Jacksonville, Fla.

FOR SALE: One year old office outfit. One Hamilton, new design, Steeltone Suite Table, two cabinets, four steel chairs, office accessories. Castle Sterilizer. All new, bought from Anderson Surgical Company, Tampa. Write J. S. Read, M.D., 41 S. Pineapple St., Sarasota. Phone Ringl. 2-5131.

INTERNIST: Interest cardiology, University trained, age 34. Part I Boards completed. Desires association with internist, clinic or practice location. Florida license. Write 69-179, P.O. Box 1018, Jacksonville, Fla.

GENERAL PRACTITIONER: Must be energetic. Some obstetrics. Share nights and weekends with two other men. Excellent salary. First year with vacation and then choice of increase in salary or percentage. New 25 room, air-conditioned building. Southeast Florida. Write 69-180, P.O. Box 1018, Jacksonville, Fla.

PEDIATRICIAN WANTED: Board or eligibility preferred but not necessary. None yet in town south east of Florida of over fifty thousand. Practice alone or association with man beginning Obst. and Gynec. Great opportunity. Hospital of 50 beds open. Write 69-177, P.O. Box 1018, Jacksonville, Fla.

INTERNIST: Board eligible, special interest gastroenterology; University trained; Veteran; desires association or assistantship with individual or group starting July 1, 1957. Write 69-178, P.O. Box 1018, Jacksonville, Fla.

FOR SALE: Retirement necessitates finding seasoned general practitioner to take over active long established practice with minimum income of $20,000 per year. Located in South Central Florida Ridge District. Fully equipped, exceptional laboratory and good hospital facilities available. Immediate occupancy. Will introduce. Price and terms nominal to right party. Write 69-181, P.O. Box 1018, Jacksonville, Fla.

FOR SALE: Established office and living quarters. Completely equipped for immediate practice. $50,000 to $65,000 gross. Two reception rooms, three examining rooms. Laboratory, X-Ray room, photo dark room. Air conditioned and sound insulated. Easy terms. Write George W. Lubke, Inc., 601 N. Atlantic, Daytona Beach, Fla.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Bennett, Edmund D., Bartow
Bennett, Willard H. H., Titusville
Blais, Michael R., Daytona Beach
Burris, Malcolm B., Lakeland
Campbell, Roy E., St. Augustine
Carter, Harvey R., Clearwater
Casey, Ernest R. Jr., Gainesville
Caswall, Thomas M., Bartow
Cofrin, David A., Gainesville
Coury, Paul E., Bartow
Faris, William E., Jacksonville
Gwaltney, Loral F., Naples
Hanson, Keith L., Orlando
Hegert, Thomas F., Orlando
Hodgins, Thomas E. Jr., Jacksonville
Hurst, Ralph E., Winter Park
Koehler, Robert O., St. Petersburg
Leech, Clifton B., Fort Lauderdale
Lester, Robert H., Arlington
MacDonald, Martha W., Sarasota
Maas, Paul, Pompano Beach
Specht, Harry O., Sarasota
Tanner, Terry F., Auburndale
Taylor, William M., Fort Myers
Torrance, Harold R., Apopka
Trimble, James R., Jacksonville
Vann, Enoch J. Jr., Vero Beach
Von Thron, Joseph C., Cocoa Beach
Warnock, Jack C. W., Fort Myers
Webster, Robert N., Tallahassee
Whorton, Carl M., Jacksonville
Wilcox, Robert N., Jacksonville
Young, Elbert L., St. Petersburg

BIRTHS AND DEATHS

Births

Dr. Lois E. Friedl (Mrs. Dallas Calhoun) and Mr. Dallas Calhoun of Kissimmee announce the birth of a daughter, Karen Maureen, on Dec. 9, 1955.

Dr. and Mrs. Benjamin F. Gatliff of Plant City announce the birth of a daughter, Eda Marie, on Dec. 25, 1955.

Deaths — Members

Gwynn, George H. Jr., Tallahassee January 28, 1956
Davis, William M., St. Petersburg February 8, 1956

Deaths — Other Doctors

Garner, John E. Sr., Thomaston, Ga. January 24, 1956
McGuigan, Cletus E., York, Pa. September 12, 1955

STATE NEWS ITEMS

Dr. Samuel M. Day of Jacksonville, secretary-treasurer of the Florida Medical Association, was principal speaker at the mid-February meeting of the Meninak Club of Jacksonville.

Dr. Curtis D. Benton Jr. of Fort Lauderdale read a scientific paper at the Fifth Congress of the Pan American Association of Ophthalmology held recently in Santiago, Chile. He was also a guest speaker at a meeting of the Uruguayan Ophthalmological Association in Montevideo, and at a meeting of the eye section of the Amazonian Association in Manaos, Brazil.

Dr. Robert C. Piper of Miami announces the removal of his offices to 3133 Ponce de Leon Boulevard, Coral Gables, for the practice of general medicine and gynecology.

The Southeastern Division Regional Meeting of the International College of Surgeons is being held at Read House in Chattanooga, Tenn., April 30 and May 1, 1956.

Dr. Frank G. Slaughter of Jacksonville was one of the principal speakers on the program for the 33rd annual meeting of the Florida Library Association held the middle of February at Jacksonville.

Dr. James N. Patterson of Tampa was the principal speaker at a meeting of the medical staff of the South Florida Baptist Hospital at Plant City early in February. His topic was "The Intelligent Choice of Laboratory Tests in Diagnosis."

Dr. William S. Hatt of Sarasota discussed corrective surgery and cerebral palsy at the winter meeting of the Florida Chapter of the American Physical Therapists Association held recently at Sarasota.

The Medical Library Association will hold its Fifty-Fifth Annual Meeting from June 18 to 22 at the Hotel Statler in Los Angeles.

Dr. William H. Proctor of West Palm Beach discussed tumors and cancers at a recent meeting of St. Mary's Hospital Auxiliary of that city.

Dr. John T. Goodgame of Clearwater has been certified as a diplomate of the American Board of Surgery.

Dr. John C. Burwell Jr., of Greensboro, N. C., has been elected president of the South Atlantic Association of Obstetricians and Gynecologists. President-elect is Dr. George A. Williams, of Atlanta, Ga. Other officers are Dr. George A. Williams, of Atlanta, vice president; Dr. C. Hampton Mauzy, of Winston-Salem, N. C., secretary-treasurer, and Dr. W. Norman Thornton, Charlottesville, Va., assistant secretary-treasurer.

Dr. Mauzy announced the names of the new officers following the recent meeting held at Hollywood, Fla. At the same time he stated that the next meeting would be held at Charleston, S. C., February 6-9, 1957.

The Second Annual Central Florida Medical Meeting has been announced for April 19 at Orlando. Registration will be in the Orange Memorial Hospital lobby and in the San Juan Hotel lobby.

Guest speakers are Dr. George Pack, Pack Medical Group and Memorial Hospital for Cancer and Allied Diseases, New York City; Dr. E. Cowles Andrus, retiring president of the American Heart Association and Professor of Medicine at Johns Hopkins Hospital, Baltimore, and Dr. Richard Varco, Professor of Surgery at the University of Minnesota Medical School, Minneapolis.

Dr. Meredith F. Campbell of Miami has been made editor for the United States for Urologia Internationalis, an international urologic journal published at Basle, Switzerland.

Dr. Christian Keedy of Miami presented a paper on "Division of the Pituitary Stalk and Its Effect on Hypertension" at the Ninth Annual Meeting of the Neurosurgical Society of America held at Miami.

Dr. Charles McC. Gray of Tampa attended the meeting of the Radiological Society of North America held at Chicago and presided over one of the scientific sessions. In February he returned to Chicago for a meeting of the Board of Chancellors of the American College of Radiology. He is chairman of the By-Laws and Resolutions Committee.

Dr. Joseph G. Seltzer of Orlando has been installed as president of the Congregation of Liberal Judaism at St. Petersburg.

Dr. Joseph J. Lowenthal of Jacksonville, president of the Duval County Medical Society, discussed "Doctor-Detailman Relationships" at a recent meeting of the Pharmaceutical Representatives Association held at Jacksonville.

P M L

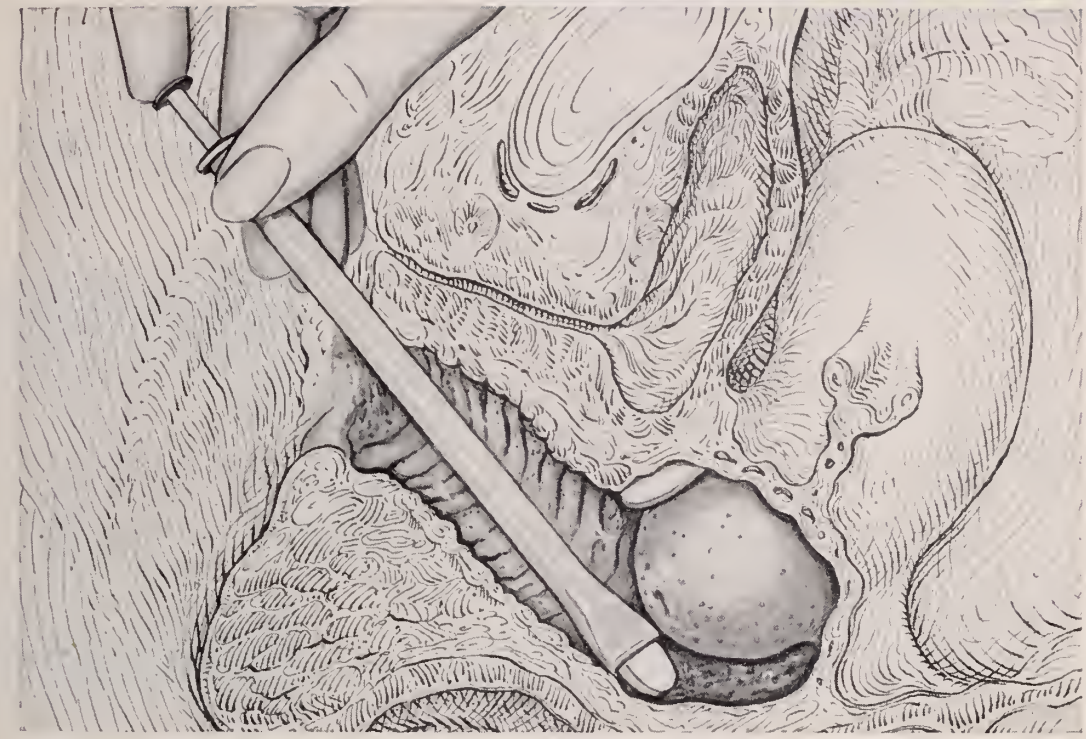
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The restorative treatment of vaginitis with Floraquin is now further improved by a new aid to tablet insertion. Faulty insertion is no longer a failure factor in therapy.

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Warm acid douches (2 ounces of 5 per cent acetic acid or white vinegar to 2 quarts of warm water) may be taken as often as desired for hygienic purposes.

Floraquin contains Diodoquin® (diiodohydroxyquinoline, U.S.P.), the safe and effective protozoacide and fungicide. Lactose, anhydrous dextrose and boric acid are included to help restore the normal acid pH of the vaginal secretions. Such an acid vaginal medium then encourages the growth of normal flora and makes the environment unfavorable for pathogens.

A Floraquin applicator is supplied with each box of 50 (a new package size) Floraquin tablets. G. D. Searle & Co., Research in the Service of Medicine.

New Floraquin Applicator and commercial package of 50 Floraquin tablets available on request to . . .

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1. the outer layer of antacids (aluminum hydroxide gel and magnesium trisilicate) comes into contact with the gastric mucosa first . . . and after it is completely dissolved . . .

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'Co-Deltra' and 'Co-Hydeltra' are now available in bottles of 30 on your prescription. Each Multiple Compressed Tablet contains:

Prednisone or Prednisolone, 5 mg.; 300 mg. of dried aluminum hydroxide gel, U.S.P., and 50 mg. of magnesium trisilicate.

'Co-Deltra' and 'Co-Hydeltra' are trade-marks of Merck & Co., Inc.

1. Bollet, A. J., Black, R., and Bunim, J. J.: *J.A.M.A.* **158**: 459, June 11, 1955.

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Prednisolone Buffered

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COMPONENT SOCIETY NOTES

Brevard

Dr. Peter B. Wright, of Orlando, was principal speaker at the February meeting of the Brevard County Medical Society. He presented a film and later discussed the Ehlers-Danlos syndrome in children. Dr. Wright is a former Professor of Orthopedics at the University of Georgia School of Medicine.

Broward

Dr. James B. Griffitts, of Miami, assistant director of the John Elliott Blood Bank of Dade county, discussed "Uses and Abuses of Transfusions" at the February meeting of the Broward County Medical Association.

Franklin-Gulf

The Franklin-Gulf County Medical Society has paid 100 per cent of its state dues for 1956.

Hillsborough

Dr. Zack Russ Jr., of Tampa, was principal speaker at the February meeting of the Hillsborough County Medical Association. His topic was "Psychiatry in the General Hospital."

Orange

Dr. Donald W. Smith, of Miami, addressed the March meeting of the Orange County Medical Society. His subject was "Surgical Nutrition: Its Relation to Changes of Plasma and Cell Volume and Protein Disequilibrium in the Surgical Patient."

Pinellas

The March meeting of the Pinellas County Medical Society featured two speakers, Drs. James K. McCorkle and Raymond K. O'Brien, both of St. Petersburg. Dr. McCorkle discussed "New Drugs" and the title of Dr. O'Brien's address was "Bed Time Stories."

Polk

"Recent Advances in Cardiovascular Surgery" was the principal topic discussed at the February meeting of the Polk County Medical Association held at the Haven Hotel in Winter Haven. The guest speaker, Dr. James O. Ferguson, of St. Petersburg, used this subject for his address.

The first Medical Forum of the 1956 series was held early in February at Lakeland. The Association was joined in sponsoring the Forums this year by the Lakeland Kiwanis Club and the Lakeland Ledger.

Lake

Dr. Louis M. Orr, of Orlando, addressed the Lake County Medical Society at the regular March meeting. His subject was the problems facing organized medicine. In his address, he enumerated these problems as the same ones facing all Americans, namely, socialization, "give-aways," and eventual and inevitable bankruptcy, unless the real substantial American in all walks of life make their voices heard. He urged all physicians to let that voice be heard.

Duval

Dr. Norman Treves, Chief of Breast Service, Memorial Hospital, New York City, was principal speaker at the March meeting of the Duval County Medical Society. The title of his address was "The Management of Recurrent and Inoperable Breast Cancer: Recent Advances."

Dade

Dr. Meredith F. Campbell, of Miami, addressed the March meeting of the Dade County Medical Association following the indoctrination course for provisional members. The title of his address was "Hermaphrodism and Other Problems in Intersex."

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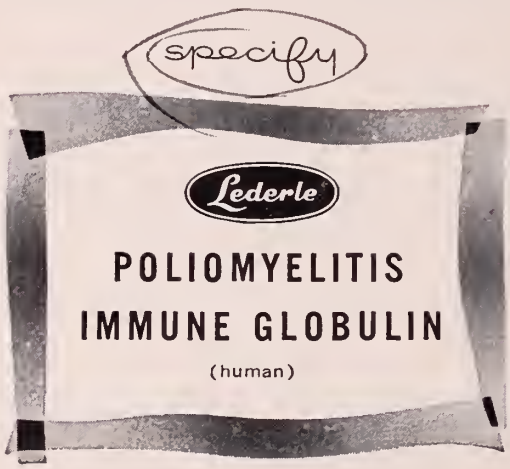
OBITUARIES

Joseph Maxwell Williams Jr.

Dr. Joseph Maxwell Williams Jr. of Tampa died in Baltimore, Md., on Sept. 25, 1955. He was 40 years of age. Interment took place in Oak Hill Cemetery near Lakeland.

Born in Troy, Ala., on Oct. 30, 1915, Dr. Williams moved with his parents to Lakeland in 1921. After attending Davidson College, Davidson, N. C., from 1932 to 1934, he transferred to Tulane University of Louisiana, where he was graduated in 1936 with a Bachelor of Science degree. He then entered the School of Medicine of his alma mater and was awarded the degree of Doctor of Medicine in 1940. He interned at Charity Hospital in New Orleans for two years and afterward served for a brief time as resident physician for the student body at the University of Florida in Gainesville.

During World War II Dr. Williams served in the Medical Corps of the Army at various station hospitals in this country. He was discharged with the rank of captain in 1945.



For the modification of measles and the prevention or attenuation of infectious hepatitis and poliomyelitis.

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Upon completion of military service, Dr. Williams became a resident physician on the staff of the Johns Hopkins Hospital in Baltimore. After serving in this post from 1945 to 1947, he entered the private practice of internal medicine in Tampa.

Locally, Dr. Williams served on the staff of the Tampa Municipal Hospital and of St. Joseph's Hospital. He was a director of the Tuberculosis Association. He was a member of the Tampa Rotary Club, the Palma Ceia Golf Club and the Tampa Yacht and Country Club. Aside from his family and the practice of medicine, his two consuming interests were his church and Boy Scout work. He was a deacon of the Hyde Park Presbyterian Church and had served as chairman of the Health and Safety Committee of the Gulf Ridge Council of the Boy Scouts of America.

Dr. Williams was a member of the Hillsborough County Medical Association and since 1948 had held membership in the Florida Medical Association. He was also a member of the American Medical Association and of the American Heart Association and was a fellow of the American College of Physicians.

In 1942 Dr. Williams was married to Miss Mary Heald of Lakeland, who survives him. Also surviving are three sons, Joseph Maxwell III, Frank Jay and Thomas Mabson, of Tampa; and his parents, Mr. and Mrs. J. M. Williams, of Lakeland.

Harry Z. Silverman

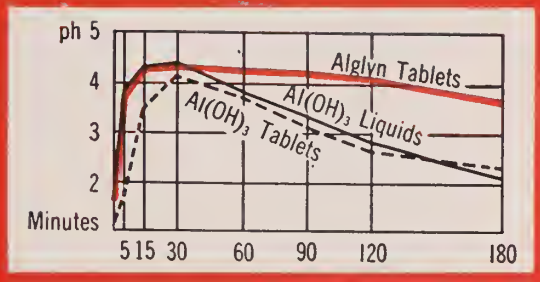
Dr. Harry Z. Silverman of Miami Beach died in a local hospital on Oct. 3, 1955. He was 57 years of age. Interment took place in Pittsburgh, Pa.

Dr. Silverman was born on Jan. 27, 1898. He received his medical training at Tufts College of Medicine in Boston and was awarded the degree of Doctor of Medicine in 1924.

The following year he was licensed in Florida and entered the general practice of medicine in Miami Beach. He was one of the earliest physicians in Miami Beach and continued to practice there for 30 years. He was a veteran of both world wars. Locally, he was on the staff of St.

(Continued on page 870)

Announcing Revision of N.N.R. Monograph for



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dihydroxy aluminum aminoacetate

On the basis of considerable *in vitro* evidence accumulated over a period of seven years, the Council on Pharmacy and Chemistry has revised the original ALGLYN monograph acknowledging that this most recent form of aluminum antacid therapy is as active—IN TABLET FORM—as the various aluminum hydroxide preparations are in LIQUID form:

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Also supplied in combination with spasmolytic and sedative therapy as **Malglyn Compound,** each tablet contains dihydroxy aluminum aminoacetate, 0.5 Gm., belladonna alkaloids, 0.162 mg., phenobarbital, 16.2 mg., per tablet, bottles of 100 (pink); and as **Belglyn,** dihydroxy aluminum aminoacetate, 0.5 Gm., belladonna alkaloids, 0.162 mg., per tablet, bottles of 100 (yellow).

Reprint of recent *in vivo* studies available on request

1. Rossett, N.E. and Rice, M.L., Jr.: Gastroenterology, 26:490, 1954.
2. Hammarlund, E.R. and Rising, L.W.: J. Am. Pharm. Assoc., Scientific Edition, 38:586, 1949.

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SOYALAC is an ideal "regular" formula. It also helps solve the feeding problems of prematures and infants requiring milk-free diets.

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(Continued from page 866)

Francis and Mt. Sinai hospitals. A member of Miami Beach Elks Lodge 1601, he was also a member of the Pioneer Club of Miami Beach and B'nai B'rith.

Dr. Silverman was a member of the Dade County Medical Association and had since 1933 been a member of the Florida Medical Association. He also held membership in the American Medical Association.

Surviving are the widow, Mrs. Ethel Silverman, of Miami Beach; one sister, Mrs. Shirley Hill, of Milford, Conn.; and two brothers, Silas Silverman, of Boston, and Samuel Silverman, of New York City.

Frank M. Hall

Dr. Frank M. Hall of Gainesville died in a Jacksonville hospital on December 23, 1955. He was 53 years of age.

Born in Gainesboro, Tenn., on Sept. 12, 1902, Dr. Hall was educated in his native state. He attended Tennessee Polytechnic Institute and completed his academic education at Vanderbilt University. He received his medical training at the University of Tennessee College of Medicine and was awarded the degree of Doctor of Medicine by that institution in 1933. Upon graduation he served an internship at Baptist Hospital in Birmingham, Ala., and later won his master's degree in public health at the Johns Hopkins University School of Medicine.

In 1944, Dr. Hall came to Gainesville as county health director. Possessed of a consuming interest in public health, he gave able leadership in this field in Alachua County, in the state and in the South. Death came as one of his major projects, the $150,000 County Health Center, which he aimed to build into one of the finest in the state, was nearing completion. He was also active in obtaining the University of Florida's J. Hillis Miller Health Center and assisted in the planning of the proposed 200 bed Alachua General Hospital.

Dr. Hall was a past president of the Southern Branch of the American Public Health Association and of the Florida Public Health Association. He had served the American Public Health Association as secretary-treasurer and as chairman of its health officers' section. He was at one time secretary of the American Association of Public Health Physicians and had served as vice presi-



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NEW

'Co-Hydeltra'

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dent of the Alachua County Medical Society. Since 1945 he had been a member of the Florida Medical Association, and he was also a member of the American Medical Association and the American College of Preventive Medicine.

Surviving are the widow, Mrs. Vera Zoder Hall; one son, Michael; one daughter, Barbara, all of Gainesville; and two brothers, Dr. J. B. Hall, Lake County health director, and Dr. Fred Hall, a dentist, of Nashville, Tenn.

(Continued from page 847)

SANDOZ PHARMACEUTICALS — 46

Sandoz Pharmaceuticals cordially invites you to visit our display at the Florida Medical Convention — Booth Number 46.

FIORINAL: A new approach to therapy of tension headaches and other head pain due to sinusitis and myalgia.

CAFERGOT: Available in oral and rectal form for effective control of head pain in migraine and other vascular headaches.

BELLERGAL: Valuable as an autonomic inhibitor in a variety of functional ills — the volume of favorable clinical reports is constantly increasing.

Any of our representatives in attendance, will gladly answer questions about these and other Sandoz products.

AMERICAN FERMENT CO., INC. — 47

Our unique demonstration of the proteolytic activity of Caroid will explain why addition of Caroid to Caroid and Bile Salts Tablets and Alcaroid provides unusual advantages when laxation or antacid therapy is indicated. Other products featured will be the palatable Essence of Caroid for improving digestion and utilization of dietary proteins; and Supligol, the whole bile-ketocholanic acid compound for management of early biliary dysfunction.

SMITH, KLINE & FRENCH LABORATORIES — 48

The S.K.F. booth will feature the latest clinical information about THORAZINE® (chlorpromazine, S.K.F.) and its many varied uses in nausea, vomiting and hiccups; anxiety and tension states; alcoholism; intractable pain; behavior disorders in children; surgery and obstetrics; senile agitation; and the emotional stress associated with certain somatic conditions.

THE NESTLÉ CO. — 49

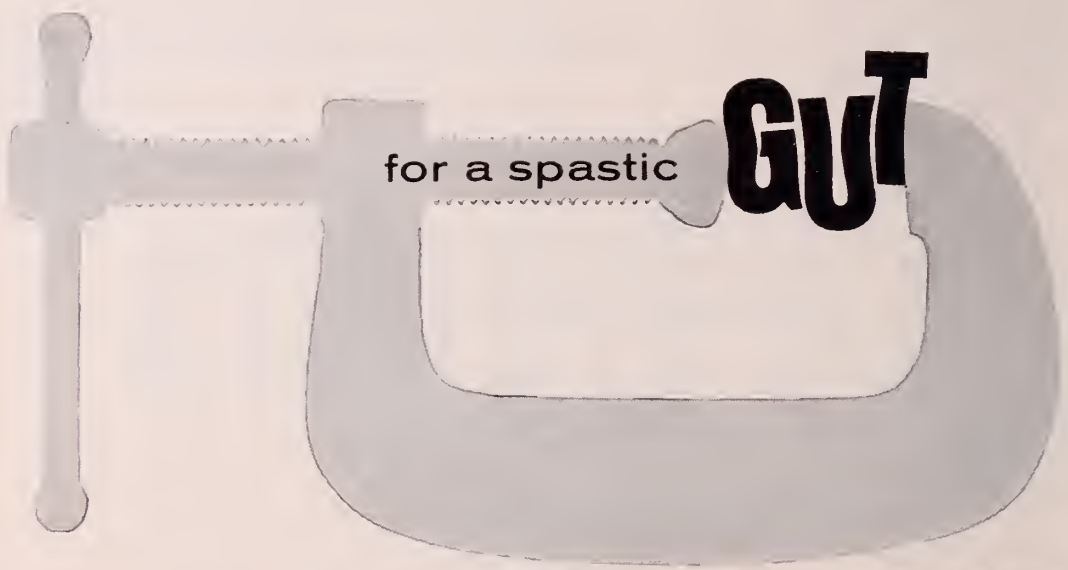
Featured in the Nestlé exhibit in Booth No. Forty-nine is Arobon, the antidiarrheal product prepared from specially processed carob flour. Clinically tested and proven, Arobon is now available in both powder and wafer forms. Also on display are the Nestlé infant feeding formula products — Lactogen, Dextrogen and Pelargon. You are cordially invited to visit the Nestlé booth where qualified representatives will be on hand to answer your questions about the products on display.

GENERAL ELECTRIC CO., X-RAY DEPT. — 50

S. J. TUTAG & CO. — 51

SURGICAL SUPPLY CO. — 52

THE SURGICAL SUPPLY COMPANY, with headquarters in Jacksonville, expects to show several items which have been developed recently. One of these will be a Cardioscope. Another item will be a display of new Stryker equipment, including the Iverson Demabrader for surgical abrasions of skin defects.



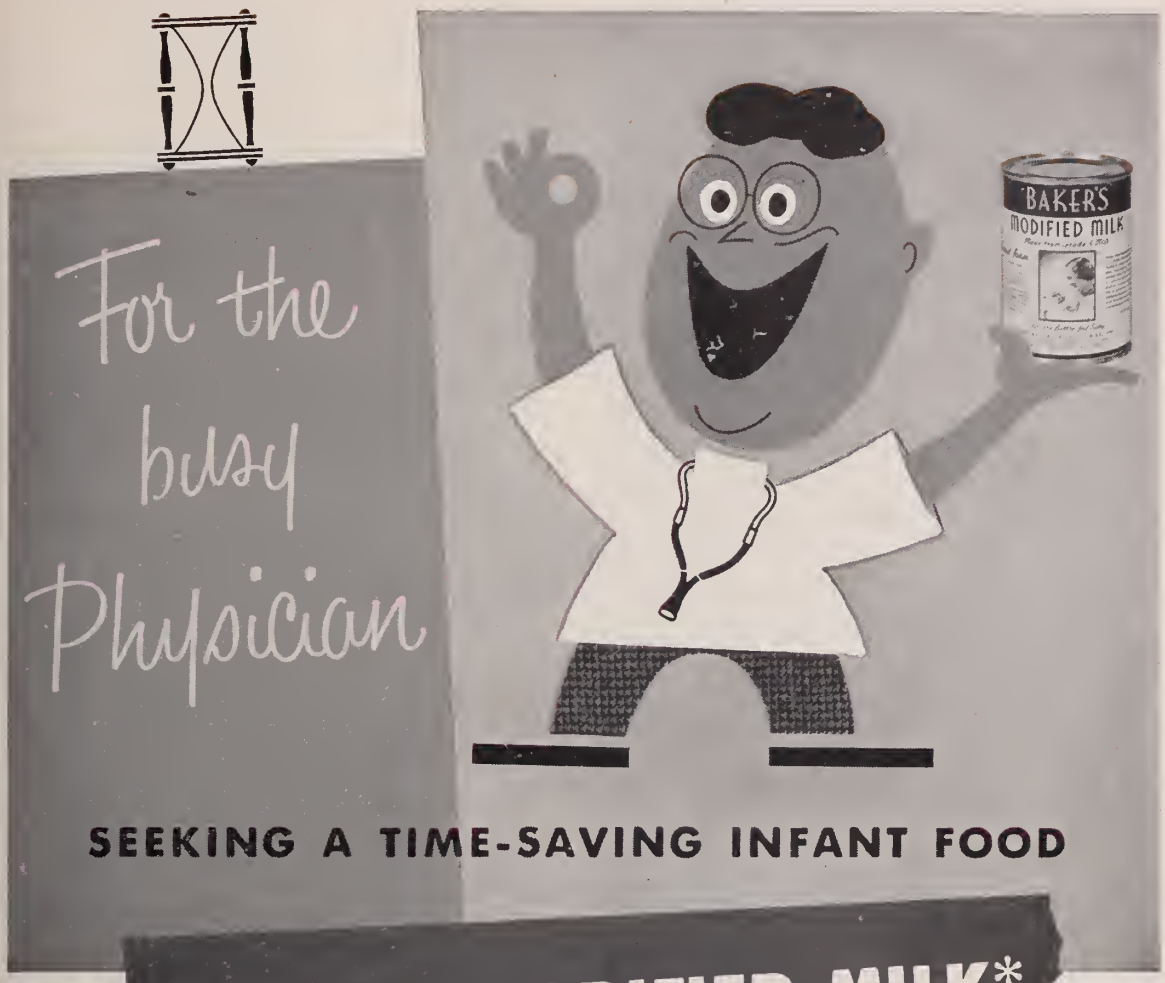
Trasentine®-Phenobarbital

integrated relief . . .
mild sedation
visceral spasmolysis
mucosal analgesia

TABLETS *(yellow, coated), each containing 50 mg. Trasentine® hydrochloride (adiphenine hydrochloride CIBA) and 20 mg. phenobarbital.*

CIBA
Summit, N. J.

2/2228M



SEEKING A TIME-SAVING INFANT FOOD

BAKER'S MODIFIED MILK*

Designed for all infant feeding from birth to the end of the first year, Baker's Modified Milk is a time-saver for busy physicians and busy hospitals. Simply dilute Baker's to prescribed strength with water.

Baker's Modified Milk is furnished gratis to all hospitals for your use.

FEEDING DIRECTIONS

(Normal dilution for liquid provides 20 calories per liquid ounce.)

	Baker's	Boiled Water
Hospital	1 part	2 parts
First week at home	1 part	1½ parts
After first week at home	1 part	1 part

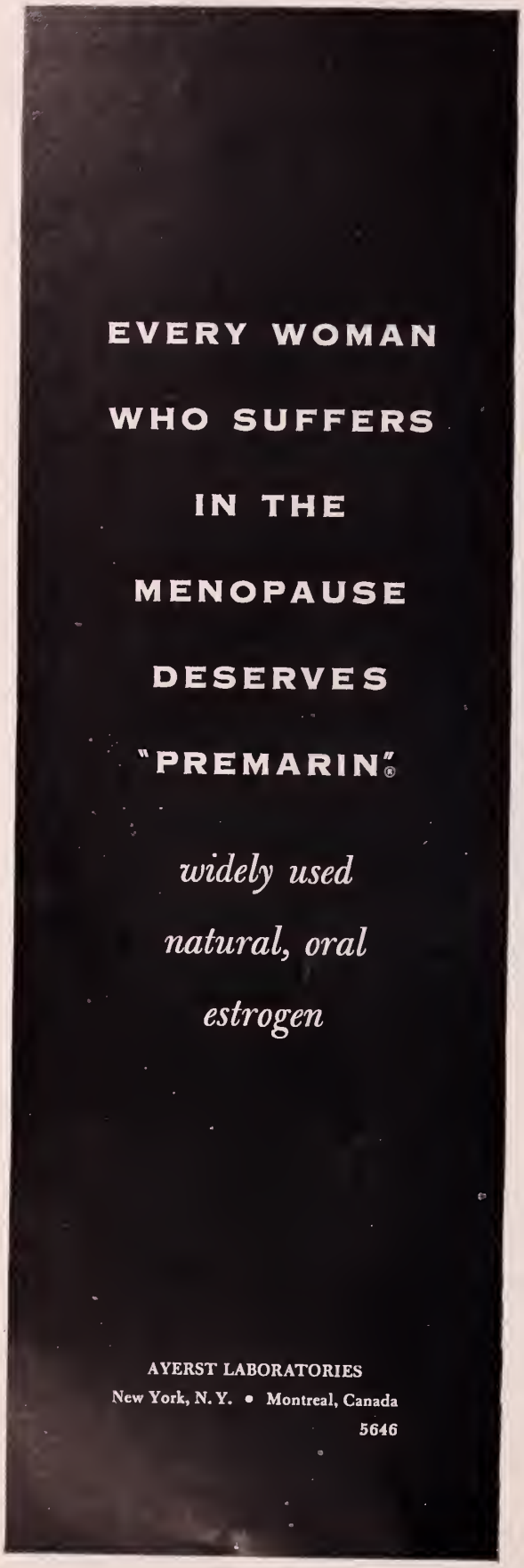
Also available in powder form. (Normal dilution one tablespoon to 2 ounces of water provides 20 calories per fluid ounce.

*Made from Grade A Milk (U.S. Public Health Service Milk Code)

THE BAKER LABORATORIES, INC.

Milk Products Exclusively for the Medical Profession

Main Office: Cleveland 3, Ohio • *Plant:* East Troy, Wisconsin



Also on display will be the latest in ultrasonic machines, as well as a complete display of useful diagnostic items for the general practitioner.

WM. P. POYTHRESS & CO. — 53

The mild sedative, SOLFOTON, in tablet and capsule form, will be featured at the Poythress exhibit. Physicians attending the convention are cordially invited to visit Booth 53 where information on all Poythress specialties will be available for the asking.

SHARP & DOHME, INC. — 54

HOLLAND-RANTOS CO., INC. — 55

Physicians interested in Medical Contraceptives are invited to discuss with Holland-Rantos representative latest information on laboratory and clinical data concerning the efficacy of KOROMEX products.

Also on display will be the trichomonacidal, bactercidal and fungicidal NYLMERATE JELLY and SOLUTION along with HOLLANDEX medicated skin ointment and other Holland-Rantos products.

M & R LABORATORIES — 56

Current concepts in infant feeding stress the critical aspects of preventive care. Visit our booth at your convenience; your Similac representative will be happy to discuss the physiologic role of Similac Powder and Similac Liquid in providing good growth, sound development, and optimum clinical benefits. Reprints of current pediatric investigations and the latest M & R Pediatric Research Conferences are available.

E. R. SQUIBB & SONS — 57

KELEKET X-RAY OF FLORIDA — 58

I well remember the first Florida Medical Association Convention in West Palm Beach, in 1928, which was the first meeting in which we exhibited X-Ray equipment.

These yearly meetings of the Florida Medical Association afford us a great opportunity to see personally so many of our old friends and we are looking forward again, with great pleasure, to the meeting at the Hotel Fontainebleau in Miami Beach, Florida — Hans B. Heether, Keleket X-Ray of Florida.

TABLEROCK LABORATORIES — 59

Tablerock proudly presents SENAZOL, a unique combination of both sex hormones with lipotropes, essential vitamins and necessary minerals plus METRAZOL, the proven safe cerebral stimulant. SENAZOL provides a multitude of factors in one dosage form of the geriatric patient's multiplicity of symptoms. Prescribe senazol for every geriatric patient . . . every day.

THE UPJOHN CO. — 60

Members of the medical profession are invited to visit the Upjohn booth where members of The Upjohn Company professional detail staff are prepared to discuss subjects of mutual interest.

SURGICAL EQUIPMENT CO. — 61

BURROUGHS WELLCOME & CO. (U.S.A.) INC.—62

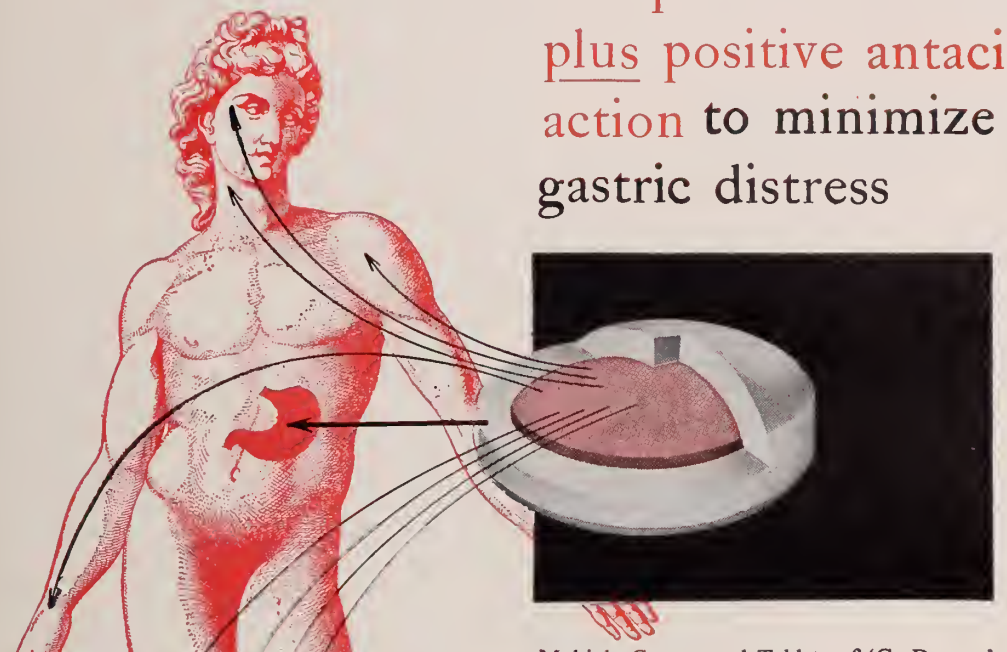
NEW PRODUCTS: The extensive research facilities of "B. W. & Co.", both here and in other countries, are directed to the development of improved therapeutic agents and techniques.

Through such research "B. W. & Co." has made notable advances related to leukemia, malaria, diabetes, and diseases of the autonomic nervous system; and to antibiotic, muscle-relaxant, antihistaminic, and antinauseant drugs.

An informed staff at our booth will welcome the opportunity to discuss our products and latest developments with you.

(Continued on Page 878)

All the benefits of prednisone and prednisolone plus positive antacid action to minimize gastric distress



Multiple Compressed Tablets of 'Co-Deltra' and 'Co-Hydeltra' are designed to help the physician cope with the problem of gastric distress which might otherwise become an obstacle to therapy with the newer steroids prednisone and prednisolone. Each Multiple Compressed Tablet is specifically formulated as a "tablet within a tablet" to provide stability and to release in sequence antacid and anti-inflammatory components.

NEW

'Co-Deltra'

Prednisone Buffered

MULTIPLE COMPRESSED TABLETS

and

'Co-Hydeltra'

Prednisolone Buffered

Supplied: Multiple Compressed Tablets of 'Co-Deltra' and 'Co-Hydeltra', each containing 5 mg. prednisone or prednisolone, 300 mg. of dried aluminum hydroxide gel, U.S.P., and 50 mg. of magnesium trisilicate, U.S.P., bottles of 30 tablets.

SHARP & DOHME

Philadelphia 1, Pa.
Division of Merck & Co., Inc.

'Co-Deltra' and 'Co-Hydeltra' are the trademarks of Merck & Co., Inc.

WOMAN'S AUXILIARY
TO THE
FLORIDA MEDICAL ASSOCIATION

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MRS. BURNS A. DOBBINS JR., Nominating..*Fort Lauderdale*
MRS. RICHARD F. STOVER, Writer for Fla. Med. Journal*Miami*

"The substitution of oral Neohydrin for parenteral meralluride was successfully accomplished in 97 per cent of 70 ambulatory clinic out-patients with chronic congestive heart failure."*

Lawrence, W. E.; Kahn, S. S., and Riser, A. B.: South. M. J. 47:105, 1954.

98656

Arkansas and Missouri Will Furnish Guests for Convention

Mrs. Mason G. Lawson, Little Rock, Ark., President of the Woman's Auxiliary to the American Medical Association, and Mrs. John J. O'Connell, St. Louis County, Missouri, President of the Woman's Auxiliary to the Southern Medical Association, will be the honored guests at the Twenty-Ninth Annual Convention of the Woman's Auxiliary to the Florida Medical Association being held at the Hotel Fontainebleau, Miami Beach, May 14-15, 1956.

Mrs. Lawson holds the distinction of having been president of two county auxiliaries. She was president of one and then moved to Little Rock with her husband and was later president of the Pulaski County Auxiliary. Dr. Lawson is in Public Health work, hence that move. In 1948-49, Mrs. Lawson was president of the Woman's Auxiliary to the Arkansas Medical Association and at the national convention of 1949 was elected a vice-president of the national auxiliary. She served two years in this capacity and two years as treasurer of the national auxiliary prior to becoming president-elect and then president.

Mrs. Lawson was sent to Florida as the national auxiliary representative for the Florida convention of 1952 and the women of the Florida Auxiliary learned to know and love her at that time. Her unassuming manner, her respect for others, her knowledge and wisdom showed her to be the type of leader that encourages others to work harmoniously together.

Mrs. Lawson has been affiliated with health work as well as with the auxiliary, having served as a member of the cancer committee in Arkansas, on the rural health committe and in other capacities. Her knowledge of the health problems and the ways of solving them is great.

Besides her charming personality, knowledge of auxiliary work and ability to lead, Mrs. Lawson is an outstanding speaker, one to whom many have turned when an outstanding speaker was needed. To hear her is a real treat, and it is our hope that those who are attending the Florida Medical Convention will not miss that opportunity. Mrs. Lawson will be the speaker at the annual luncheon to be held at the Fontainebleau Hotel at 1 p.m. on Monday, May 14.

Mrs. John J. O'Connell has served as president of her local auxiliary and also as state president of the Woman's Auxiliary to the Missouri Medi-

(Continued on page 878)



. . . and then I says to him, "if you're in that much of a jam, you'd better

call the MEDICAL SUPPLY MAN!"

And that's exactly what he did, Gertrude! Almost everybody in the medical profession knows it's always a good idea to call the Medical Supply man when they need help. And there's a good reason for this!

Normally, the Medical Supply Company handles more than 15,000 individual items made by nearly 600 manufacturers. Doctors know that the best and fastest way to get the equipment and supplies they need, is to call the Medical Supply Man. They know, too, that when old equipment and instruments won't work right, Medical Supply can put them in tip-top shape again!

So, when you need help, never neglect that impulse . . . CALL THE MEDICAL SUPPLY MAN! He'll do everything he can to get you what you want, when you want it.

HOSPITAL, PHYSICIANS and LABORATORY SUPPLIES & EQUIPMENT

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of Jacksonville

Essentials For Scientific Progress

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(Continued from page 876)

cal Association. She has also served in numerous capacities in the Southern Auxiliary including Doctor's Day Chairman, Councilor from Missouri, Treasurer and others.

Dr. and Mrs. O'Connell are now spending some of their time in well deserved travel for she, with her husband, has reared a family of twelve children. All the children are doing well and are assuming their places as fine, upstanding citizens and workers for the welfare of their communities, state and nation.

Mrs. O'Connell has the charm of a real Louisiana lady for that was where she was born. She is thoughtful of others, humble, gracious and has a happy personality. No job that she has ever taken has gone undone but has always been done to the best of her ability and that ability is outstanding.

Many of the Florida women who have attended Southern conventions have met Mrs. O'Connell and will be happy to see her here in Florida at the Convention.

Mrs. O'Connell will bring a message from Southern during the business meeting of the Florida Auxiliary which will be held at the Hotel Fontainebleau, Miami Beach at 9 a.m. on Monday, May 14.

Mrs. Samuel S. Lombardo, President, Woman's Auxiliary to the Florida Medical Association, will preside at this meeting and has planned a truly fine program. With her usual charm and aplomb, we are sure that everyone can look forward to a fine meeting with a charming presiding officer and two outstanding guests. Don't miss being there, if you do you will miss a real treat.

Mrs. Richard F. Stover

(Continued from page 874)

ABBOTT LABORATORIES — 63

PARCO SURGICAL SUPPLIES — 64

Please stop by our booth. Parco representatives will be on hand to welcome you. We will appreciate an opportunity to discuss equipment needs or supply requirements with you.

VANPELT & BROWN, INC. — 65

VanPelt and Brown extend a cordial invitation to visit their exhibit where representatives will be happy to answer questions and supply clinical samples of their products.

BILHUBER-KNOLL CORP. — 66

Oral METRAZOL is indicated for the aged patient where senile confusion, convalescence or fatigue are present. New information and literature on this therapy is available and your discussion is invited.

Information concerning the use of TENSODIN in coronary disease as well as DILAUDID, BROMURAL, QUADRINAL, THEOCALCIN and the other Bilhuber

New
Evidence
on

Rauwiloid®

confirms and defines superiority over other Rauwolfia preparations in the treatment of HYPERTENSION

- Rauwiloid represents the balanced, mutually potentiated actions[1] of several Rauwolfia alkaloids, of which reserpine and the equally antihypertensive rescinnamine have been isolated.
- Hence, reserpine is not the total active antihypertensive principle of the rauwolfia plant.
- Rauwiloid is freed of the undesirable alkaloids of the whole rauwolfia root. Recent investigations confirm the desirability of Rauwiloid (because of the balanced action of its contained alkaloids) over single alkaloidal preparations; "...mental depression...was...less frequent with alseroxylon..."[2]

The dose-response curve of Rauwiloid is flat, and its dosage is uncomplicated and easy to prescribe...merely two 2mg. tablets at bedtime.

1. Cronheim, G., and Toekes, I. M.; Comparison of Sedative Properties of Single Alkaloids of Rauwolfia and Their Mixtures, Meet. Am. Soc. Pharmacol. & Exper. Therap., Iowa City, Iowa, Sept. 5, 1955.

2. Moyer, J. H.; Dennis, E., and Ford, R.: Drug Therapy (Rauwolfia) of Hypertension. II. A Comparative Study of Different Extracts of Rauwolfia When Each Is Used Alone (Orally) for Therapy of Ambulatory Patients with Hypertension, A.M.A. Arch. Int. Med. *96*:530 (Oct.) 1955.

Riker
LOS ANGELES

Rauwiloid is the original alseroxylon fraction of India-grown Rauwolfia serpentina, Benth., a Riker research development.

chemicals is also available. You are invited to discuss these preparations with our representatives.

LLOYD BROTHERS, INC. — 67

RONCOVITE and DOXINATE, both original products of Lloyd research, will be featured at this display. Lloyd representatives will present the latest clinical studies on Roncovite, the first true hematopoietic stimulant as well as the complete story of Doxinate, the new non-laxative method of preventing and treating constipation.

IVES-CAMERON CO. 68

THE DOHO CHEMICAL CORP. 69

DOHO CHEMICAL CORPORATION is pleased to exhibit: AURALGAN, the ear medication for the relief of pain Otitis Media and removal of Cerumen; NEW OTOSMOSAN, the effective, non-toxic ear medication which is Fungicidal and Bactericidal (gram negative-gram positive) in the suppurative and aural dermatomycotic ears; RHINALGAN, the nasal decongestant which is free from systemic or circulatory effect and equally safe to use on infants as well as the aged.

Mallon Chemical Corporation, subsidiary of the Doho Chemical Corporation, is also featuring: RECTALGAN, the liquid topical anesthesia, also for relief of pain and discomfiture in hemorrhoids, pruritus and perineal suturing. DERMOPLAST, in an aerosol freon propellent spray for fast relief of surface pain, itching, burns and abrasions. Also Obs. & Gyn. use.

THE PURDUE FREDERICK CO. — 70

The Purdue Frederick Company will feature: SENOKOT — new non-bulk, non-irritating constipation corrective acting selective on the parasympathetic (Auerbach's) plexus in the large bowel, physiologically stimulating the neuromuscular defecatory reflex; PREMENS — the multidimensional premenstrual tension therapy; COLPOTAB — a tested effective Tyrothricin trichomonacide; and CHLOROGIENE — a hygienic douche formulation.

A. S. ALOE CO. — 71-72

GERBER PRODUCTS CO. — 73

When milk is contraindicated as the basic food for infants, Gerber "Meat Base Formula" can provide a nutritionally adequate replacement. It is well accepted and tolerated by infants of all ages. Your Gerber detailman invites you to evaluate "Meat Base Formula" and the complete line of supplementary baby foods.

You are also invited to review new editions of Gerber's baby care booklets. Each is designed especially for distribution by physicians. Each provides non-controversial information in simple, easy-to-understand language. The service is complimentary.

BRAYTEN PHARMACEUTICAL CO. — 74

MALTBIE LABORATORIES DIVISION
WALLACE & TIERNAN, INC. — 75

You are cordially invited to visit the Maltbie exhibit to meet our representatives and discuss our ethical pharmaceutical products. Featured items will be DESENEX and SALUNDEK, the well-known fungicides; CHOLAN HMB, for comprehensive biliary therapy; MALCOTRAN, the potent auticholinergic with wide margin of safety; and CALPURATE, for improved cardiac function and increased diuresis.

JULIUS SCHMID, INC. — 76

ENCYCLOPEDIA AMERICANA — 77

You are invited to visit booth 77 and inspect our 1956 edition of Encyclopedia Americana.

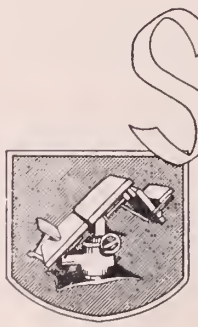
The State of Florida Librarian has this to say: "The Americana is the best Encyclopedia published" and

OUR SERVICE—Excelled by none

OUR SALESMEN—Helpful, always willing to serve

OUR STOCK—Well balanced - adequate

OUR DESIRE—To supply your needs to make your work easier



Surgical SUPPLY COMPANY

AMERICAN SURGICAL TRADE ASSOCIATION A.S.T.A.

1050 W. Adams St. P. O. Box 2580 Jacksonville, Fla.



Re-activate the arthritic

MOST POTENT ANTI-RHEUMATIC *

Sterane

Even where hydrocortisone, cortisone, and other agents had failed, prednisolone (STERANE) restored articular mobility and functional capacity to normal in rheumatoid arthritis.[1]

Four times more effective than hydrocortisone, and, on the basis of preliminary findings,[2,3] superior in potency even to prednisone (cortisone analog), STERANE is also relatively free of such hormonal side effects as edema, hypertension, or hypopotassemia.

Supplied: White, 5 mg. oral tablets, in bottles of 20 and 100. Pink, 1 mg. oral tablets, in bottles of 100. Both are deep-scored and in the distinctive "easy-to-break" size and Pfizer oval shape.

References: 1. Bunim, J. J., et al.: J.A.M.A. 157:311, 1955. 2. Forsham, P. H., et al.: Paper presented at First internat. Conf. on Prednisone and Prednisolone, New York, May 31-June 1, 1955. 3. Perlman, P. L., and Tolksdorf, S.: Scientific Exhibit presented at A.M.A. Annual Meet., Atlantic City, June 6-11, 1955.

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc. Brooklyn 6, New York

*brand of prednisolone

Florida State School Board of Public Instruction concurs.

Those who register at our booth will receive a beautiful 48 page Hammond atlas by mail. No obligation.

SHERMAN LABORATORIES — 78

PROTAMIDE: A sterile colloidal solution of denatured proteolytic enzyme. Published clinical studies have convincingly established Protamide's value in neuritis, herpes zoster and other nerve root pains.

ELIXOPHYLLIN: Our newest product for reducing the frequency and severity of asthmatic attacks. Contains theophylline in complete hydro-alcoholic solution. It provides fast absorption of theophylline for higher blood levels — also an immediate effect on the threshold of the "alarm reaction" by virtue of its alcohol content.

ENCYCLOPAEDIA BRITANNICA, INC. — 79

HART DRUG CORP. — 80

The Hart-Drug Corporation, 25 N. E. 25th Street, Miami, Florida, was established in 1927 to manufacture quality pharmaceuticals for use by the medical profession. Featured at their booth will be: (1) ALUTED, a new, dual-action tablet for the relief of asthma, (2) HARTGEL, a pleasant tasting, new aluminum hydroxide gel, which has the ability to neutralize larger amounts of acid, and (3) MIADYNE, a tablet which utilizes vasodilation plus analgesia in the relief of dysmenorrhea and premenstrual headache.

MEDICAL SUPPLY CO. OF JACKSONVILLE — 81

Medical Supply Company of Jacksonville and Medical Supply Company, Orlando have recently been appointed a dealer for the Liebel-Flarsheim Company of Cincinnati, Ohio, manufacturers of Electromedical and Electrosurgical Apparatus. We will have on exhibit Bovie Electro surgical Units, L-F Diathermy Units, Basalmeter Self-Calculating Basal Metabolism Units. We would appreciate a visit to Booth No. Eighty-one for demonstration.

J. E. HANGER, INC. — 82

A display of orthopedic and prosthetic appliances emphasizing the latest in materials, methods and construction.

A Hyper Extension Brace suggesting a new principle of applying pressure.

A Plastic Arm complete with Cine-Plasty Transmission and APRL Hand.

Custom Made Orthopedic Shoes with Lasts.

CHARLES C. HASKELL & CO., INC. — 83

The Haskell Company's ethical prescription specialties — BELBARB (antispasmodic, sedative), HASAMAL (analgesic), SILMIDATE-M (analgesic, muscle relaxant), QUERSERPIN (tranquilizer, antihypertensive) — will be exhibited. Our representatives will be present to welcome physicians and discuss any questions they might have.

A. H. ROBINS CO., INC. — 84

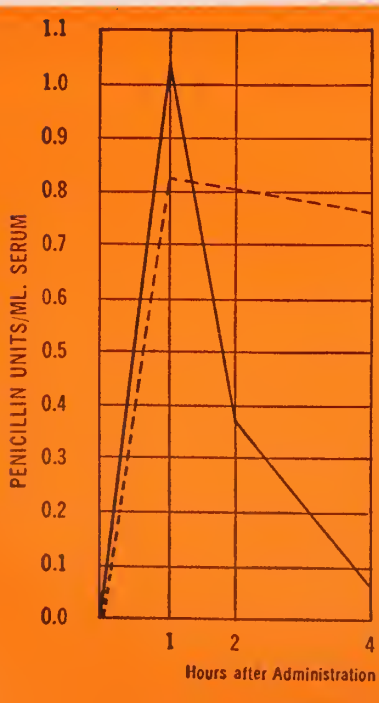
Physicians attending the meeting of the Florida Medical Association are extended a cordial invitation to visit the exhibit of the products of the A. H. Robins Company.

Experienced medical representatives will be in attendance to welcome you and answer inquiries relative to any of Robins' prescription specialties.

J. B. ROERIG & CO. — 85

Doctors and their friends are cordially invited to visit the J. B. Roerig and Company booth where information will be available on all the well known Roerig preparations. STIMAVITE, specially designed for children who don't eat well. BONADOXIN, for the prevention of nausea and vomiting of pregnancy and postoperatively

Now! Palatable Oral Suspension Gives Higher, Faster Blood Levels than Twice the Dose of Injected Procaine Penicillin



PEN·VEE·Suspension, 300,000 units

Procaine Penicillin G, 600,000 units (one injection)

This ready-mixed, stable, and pleasantly flavored suspension is supplied as follows: PEN·VEE·*Suspension*, 300,000 units per 5-cc. teaspoonful, bottles of 2 fl. oz. Also available: PEN·VEE·*Oral* Tablets, 200,000 units, scored, bottles of 36; 500,000 units, scored, bottles of

PEN·VEE*·*Suspension*

Benzathine Penicillin V Oral Suspension

ORAL PENICILLIN WITH *INJECTION* PERFORMANCE

Wyeth®
Philadelphia 1, Pa.

When Appetites Lag and Spirits are Low

There may not be too many pleasant anticipations in the lives of your elderly or convalescent patients—but a glass of wine before meals or at bedtime can give a much needed "lift" not only to appetite but to spirits.

Moreover, the use of wine for its "tonic" effect need no longer be based on empiricism or age-old tradition. Recent research is shedding new light on the true rationale of wine in clinical practice.

Thus it has been shown recently that:

—2 or 3 ounces of dry table wine can markedly increase olfactory acuity and appetite in anorexia

—moderate amounts of wine increase appreciably not only the volume but the proteolytic power of gastric juice

—the buffering action of the phosphates, organic acids and tannins in wine induces a sustained increase in gastric secretion and gastric motility

—wine offers a quickly metabolized source of nutrient energy

—wine possesses significant diuretic, vasodilating and relaxing properties—ideal for bedtime sedation

For a few cents a day your patients can have wines produced from the world's finest grape varieties, grown in an ideal climate and handled with consummate skill.

A copy of "Uses of Wine in Medical Practice"—summarizing recent research findings—is available to you at no expense, by writing to: Wine Advisory Board, 717 Market Street, San Francisco 3, California.

TO PROMOTE
Resistance to Stress
THROUGH
Total Care OF THE PATIENT



Susceptibility to the effects of stress, physical or psychic, is aggravated by a poor nutritional state; **resistance and recovery are promoted by enhanced nutrition.**

In repair, use of energy and amino acids is increased with concomitant increase in demand for vitamins of the B complex. In many clinics, VITA-FOOD Brewers' Yeast is a routine, a vital aid to **total care** of the patient—emphasized anew as the rationally inclusive approach to ideal treatment.

VITA-FOOD Brewers' Yeast

Samples and literature available on request
Vitamin Food Co., Inc., Newark 4, N. J.

NEOBON, for the adult over 40. VI-THYRO, for the vitalized thyroid. ASF, an anti-stress formulation. Also on VITERRA, VITERRA THERAPEUTIC, AMPLUS, OBRON, OBRON HEMATINIC and HEPTUNA PLUS. Literature and clinical material will be available on request.

SCHERING CORP. — 86

A cordial invitation is extended to the members of the Florida Medical Association to visit the Schering exhibit, Booth No. Eighty-six. The entire exhibit will be devoted to METICORTEN and METICORTELONE, the new corticosteroids for the treatment of rheumatoid arthritis, intractable asthma and other so-called collagen diseases. Extensive clinical and laboratory data demonstrating certain advantages of these new steroids over cortisone and hydrocortisone are shown.

BOOKS RECEIVED

Ciba Foundation Colloquia on Endrocrinology, Volume VIII, The Human Adrenal Cortex. Editors for the Ciba Foundation, G. E. W. Wolstenholme, O.B.E., M.A., B.Ch., and Margaret P. Cameron, M.A., A.B.L.S. Pp. 665. Illus. 277. Price, $10.00. Boston, Little, Brown and Company, 1955.

This new Ciba Foundation volume is devoted exclusively to the human adrenal cortex. Because of the great interest in this field and the extent of the material to be considered, this particular volume is considerably larger than previous Ciba Foundation publications. Consisting of more than 650 pages, it is divided into two divisions. The first is concerned mainly with histologic and biochemical aspects and corticomedullary relationships, and the second deals with physiology and pathologic aspects and hypothalamic and pituitary relationships.

While the primary concern was with the human adrenal cortex at the international conference of which this volume contains the proceedings, useful supporting information from animal experiments was not excluded. The reader will also observe that considerable latitude, in reference to animal work and to more general endocrinologic physiology, was permitted to the authors who were considering the influence of hypothalamus and pituitary on the adrenal cortex. Special attention is directed to chapters on the reaction of the adrenal cortex in conditions of stress, metabolism of adrenocortical steroids in humans, discussions on the biosynthesis and clinical and metabolic effects of aldosterone, Cushing's syndrome and many others.

Community Programs for Mental Health: *Theory, Practice, Evaluation...* Edited by Ruth Kotinsky and Helen L. Witmer. Pp. 362. Price, $5.00. Published for The Commonwealth Fund by Harvard University Press, Cambridge, Massachusetts, 1955.

This Commonwealth Fund book, published in November 1955, provides an over-all view of mental health promotion — its underlying theory, typical practice, and problems of evaluation. Eight distinguished contributors present papers, each of which, from its own vantage point, focuses on the surge to find means for sustaining and furthering the mental and emotional health of all, in contrast to exclusive preoccupation with curing the emotional distress or mental illness of first one individual and then another. The findings and analyses of these authorities are of the greatest importance, for they will inevitably stimulate further thought and action in this fertile area of public health and welfare, which these investigators found much less clearly defined than had been assumed. Teachers, students, and practitioners of psychology and psychiatry, and of social work and nursing, and research workers in the social sciences generally, will all value this book.

Variety is the "spice" of the bland diet...

Variety in taste and texture of foods must become the "spice" of a bland diet now that your patient can't have sharp seasonings and strongly flavored vegetables. These "do's" will help keep his diet tempting to both eye and palate.

For the "meat" of the meal—

Suggest that beef, lamb, and poultry be roasted or broiled and seasoned with salt and mild herbs.

Meat patties stay tender when crushed corn flakes and a little water are added to the finely ground beef. Salt and a hint of thyme or marjoram give savor.

Fish soufflé—flaked fish in any soufflé recipe—is a delicate delight when the top is crisped with cracker meal and butter.

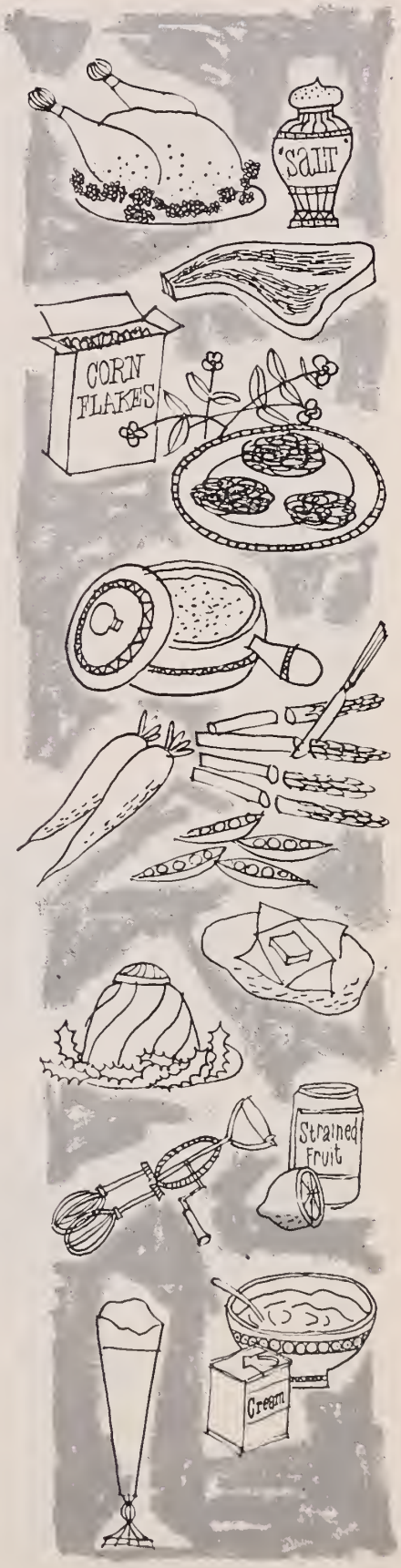
Add the "trimmings" with imagination—

Vegetables such as string beans, peas, asparagus tips, and carrots may be cooked and served whole if young and tender—otherwise pureed. Potatoes may be boiled, baked, or mashed.

Salads of molded gelatin are pretty to look at—better to eat. Your patient may like one of strained beets livened with lemon juice, chilled, and served on shredded tender lettuce.

For dessert he can try applesauce added to whipped lime gelatin, chilled and topped with custard sauce. Or for a party touch, sweeten chilled strained fruit, add a squeeze of lemon, and fold into whipped cream or whipped evaporated milk.

These "diet do's" will help your patient discover new combinations of acceptable foods. And with a glass of beer* —at your discretion—to add zest, he'll find his diet interesting and ample without straying from your instructions.



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Vascular Surgery in World War II. Edited by Daniel C. Elkin, M.D., and Michael E. DeBakey, M.D. Pp. 463. Washington, D. C., Office of the Surgeon General, Department of the Army, 1955.

As part of the history of the Medical Department of the United States Army in World War II, this volume is one of the Professional, or clinical and technical, series published as The Medical Department of the United States Army under the direction of the Office of The Surgeon General. It offers mute but convincing testimony to the vast progress recently recorded in the field of vascular surgery. In the medical history of World War I this subject was dismissed with a single paragraph; now it commands an entire volume, indicating that vascular surgery has indeed come of age.

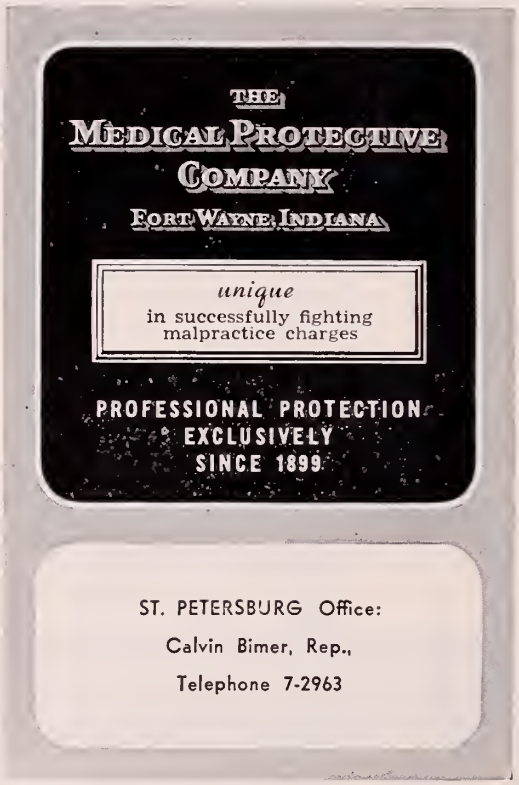
This volume purports to give a reasonably complete accounting of complications which followed combat-incurred vascular injuries in casualties evacuated to the Zone of Interior. It also includes an accounting of peripheral vascular disorders observed in Army personnel during World War II, with the exception of trenchfoot, immersion foot, and cold injuries, which will be discussed in a separate volume in the Medical History series.

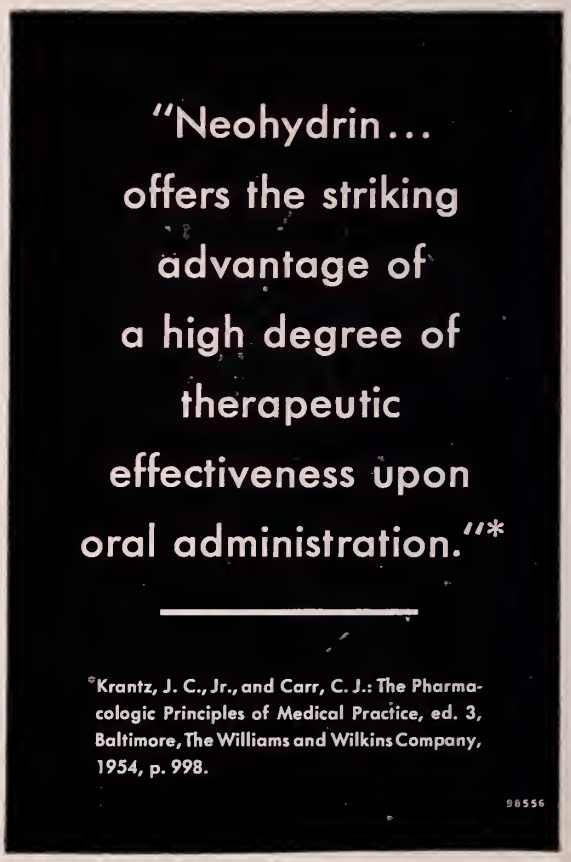
The difficult problem of supplying competent specialized care for the numbers of casualties with vascular injuries was solved in this war by the establishment of three vascular centers. Thus, for the first time in history there was a concentration of clinical material under the supervision of specialists who could carry out concurrently definitive treatment and important phases of clinical investigation. The lessons learned, as reflected in the low mortality rate and the remarkable functional results achieved in these centers, are here recorded, and "those who had part in it prayerfully hope that these lessons will not soon be forgotten." The volume should be of wide interest to surgeons in and out of military service.

Hand Surgery, *Medical Department, United States Army, Surgery in World War II.* Edited by Sterling Bunnell, M.D. Pp. 447. Washington, D.C., Office of the Surgeon General, Department of the Army, 1955.

During World War II hand surgery achieved considerable progress. Much of this success in salvaging crippled hands was due to the vision and initiative of the then Surgeon General, Major General Norman T. Kirk, who determined to consider them a special group, worthy of segregation and treatment as such. By reason of his decision, there were established overseas various hand services, and in the Zone of Interior nine hand centers, staffed by specially trained officers versed in plastic surgery, orthopedic surgery, and neurosurgery. In these centers "a plan of action and approach was crystallized — the position of function was obtained by spring or elastic splints; new cover was applied; the skeleton realined; nerves and tendons repaired; and digits positioned and transferred, or rebuilt, to give sensation and prehension."

This book records what was learned in hand surgery so that such knowledge may be utilized in any future conflict. The first chapter covers the hiatus between the two World Wars. The second is a résumé of the work on reconstruction of hands. Accounts of experiences in the Mediterranean Theater of Operations and in the European theater follow. Thereafter, each of the officers in charge of hand reconstruction in the nine hospitals in the Zone of Interior recounts the activities within his sphere of operation. The volume as a whole is inspirational and a tribute to those who served so faithfully and with such success. It should be of interest and a useful reference to thousands of surgeons who have served, are serving, or may be called upon in future to serve in the United States Army.





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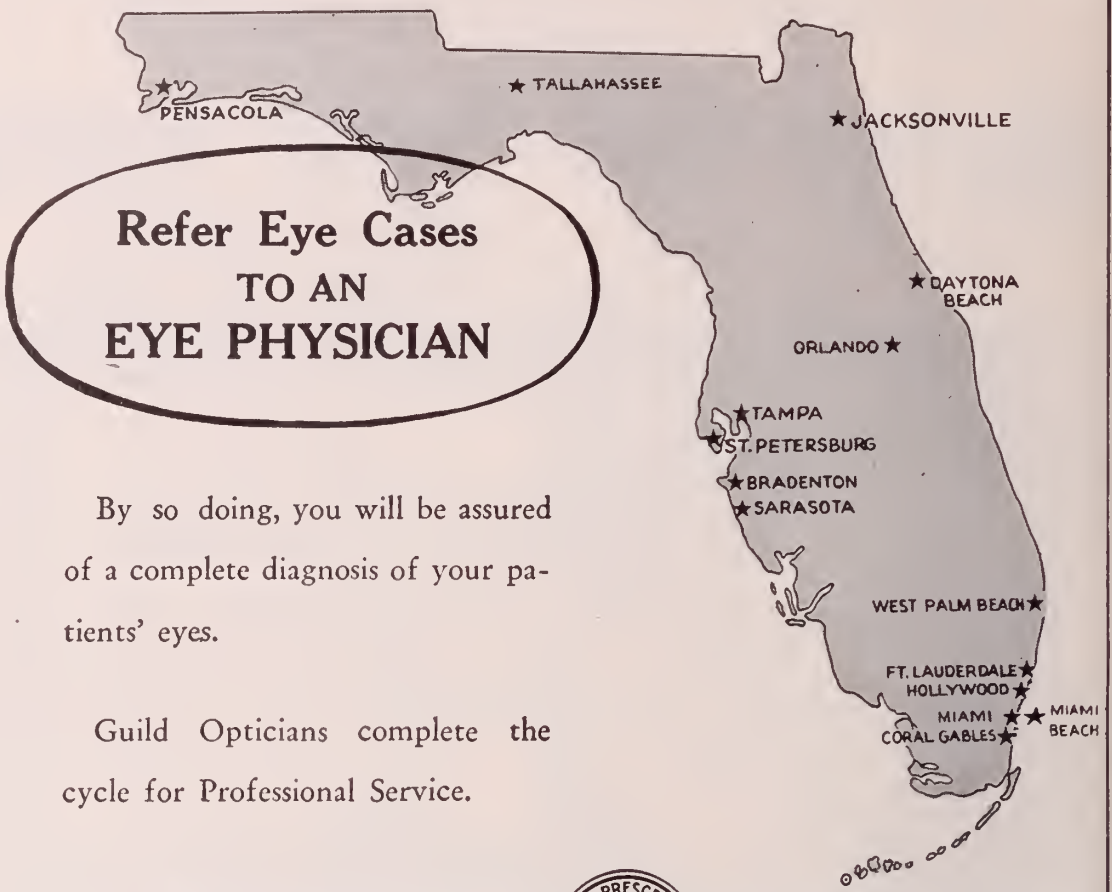


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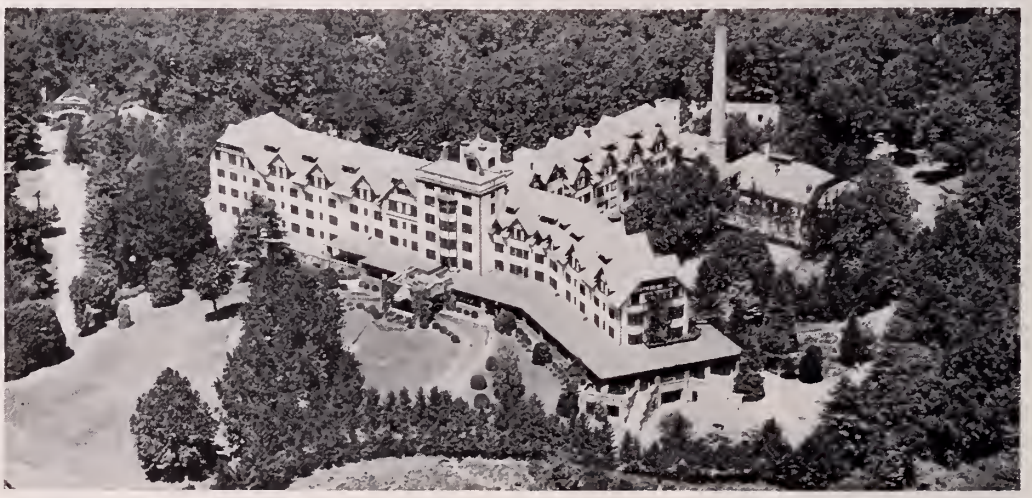
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Broward	Thomas F. Huey Jr., Fort Lauderdale	Anthony C. Galluccio, Hollywood	4th Tues.	121
Columbia	Thomas H. Bates, Lake City	Clifton G. York, Lake City	1st Mon.	11
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Duval	Joseph J. Lowenthal, Jacksonville	Charles F. McCrory, Jacksonville	1st Tues.	298
***Clay**				
Escambia	Gretchen V. Squires, Pensacola	Pascal G. Batson Jr., Pensacola	2nd Tues.	105
***Santa Rosa**				
Franklin-Gulf	Harold B. Canning, Wewahitchka	Photis J. Nichols, Apalachicola	Last Wed.	6
Hillsborough	James N. Patterson, Tampa	James A. Winslow Jr., Tampa	1st Tues.	196
Indian River	Vernon L. Fromang, Vero Beach	Enoch J. Vann Jr., Vero Beach	2nd Tues.	8
Jackson-Calhoun	Richard H. Schulz, Marianna	Francis M. Watson, Marianna	Quarterly	16
Lake	Geoffrey H. Binneveld, Leesburg	J. Basil Hall, Tavares	1st Wed.	25
***Sumter**				
Lee-Charlotte-Collier-Hendry	Joseph L. Selden Jr., Fort Myers	George D. Hopkins II, Fort Myers	3rd Mon.	37
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Manatee	Richard V. Meaney, Bradenton	Eugene E. Biel, Bradenton	2nd Tues.	29
Marion	William J. McGovern, Ocala	Robert L. Gibson, Ocala	3rd Tues.	30
***Levy**				
Monroe	Allen Shepard, Key West	William R. Ploss, Key West	1st Thurs.	14
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Orange	Thomas C. Butt, Orlando	W. Ansell Derrick, Orlando	3rd Wed.	184
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Putnam	Bennie J. Massey, Palatka	Bernard E. Kane, Crescent City	2nd Tues.	9
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Taylor	Ralph J. Greene, Perry	John H. Parker Jr., Perry	Last Fri.	5
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***Flagler**				
Walton-Okaloosa	Henry C. White Jr.. Fort Walton Bch.	George W. Barrow Jr.. Crestview	3rd Tues.	3
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Vol. XLII MAY, 1956 No. 11

EIGHTY-SECOND ANNUAL MEETING
MIAMI BEACH, MAY 13-16, 1956

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George H. Garmany

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Everett H. Williams Jr., M.S. in Hyg.

Successful Treatment of Bacterial Endocarditis
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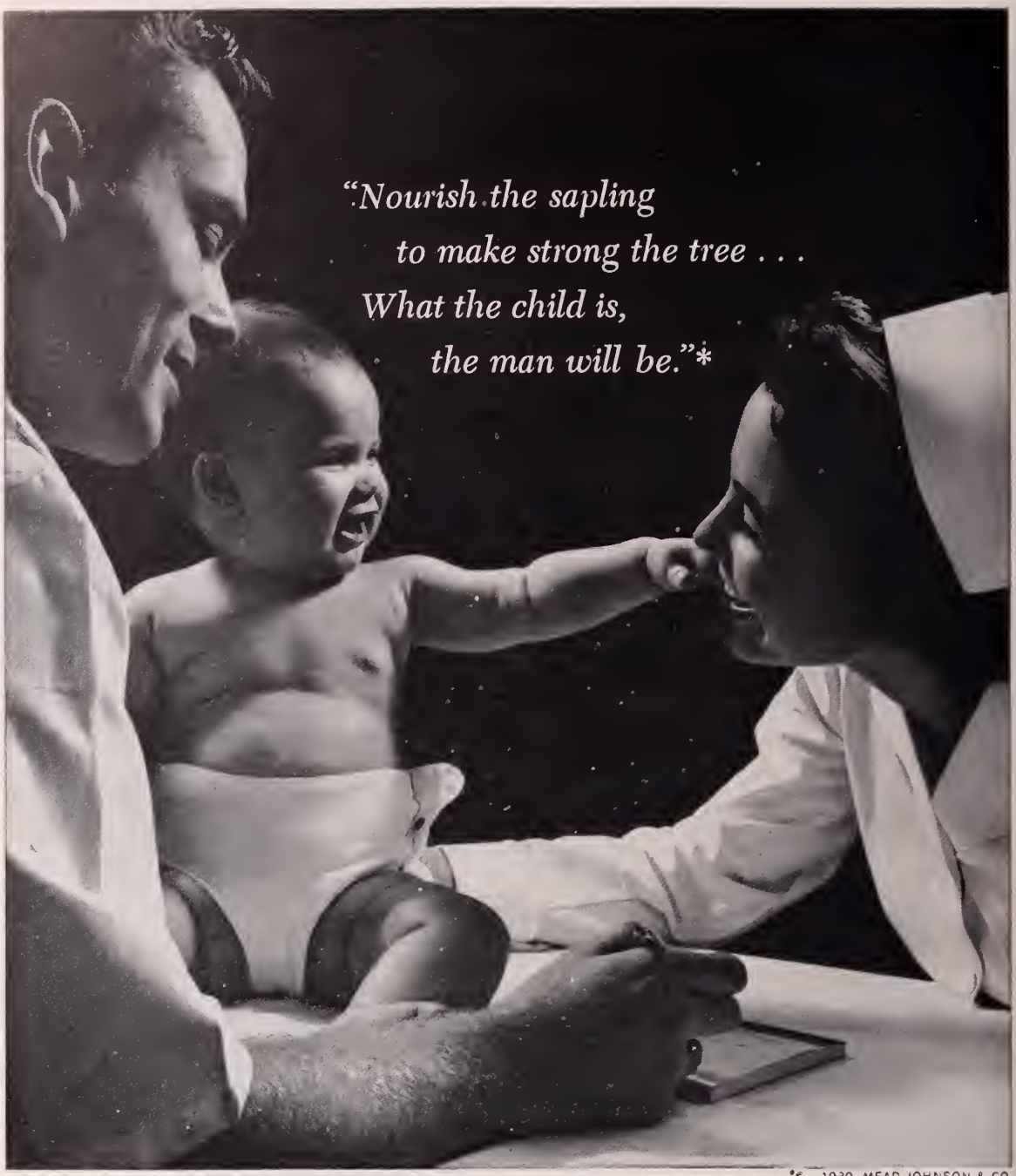
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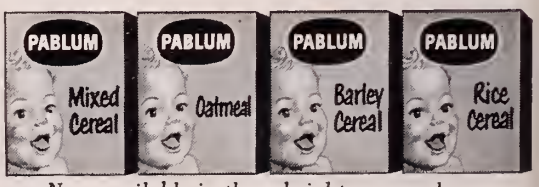
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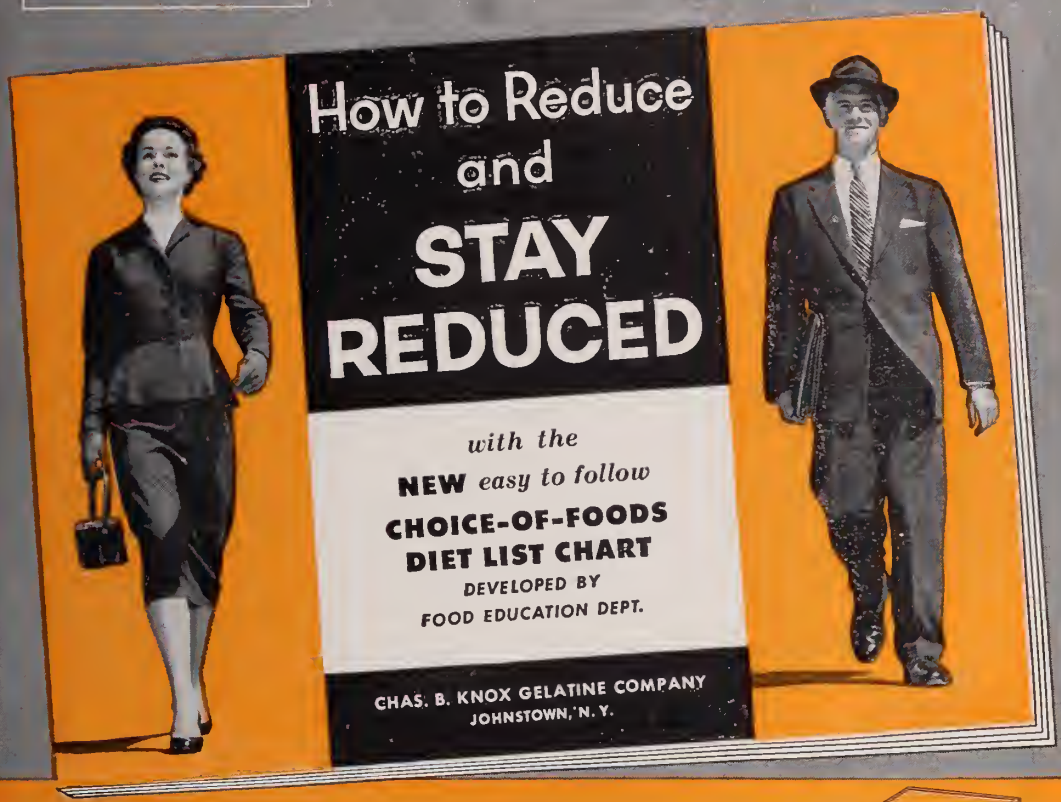
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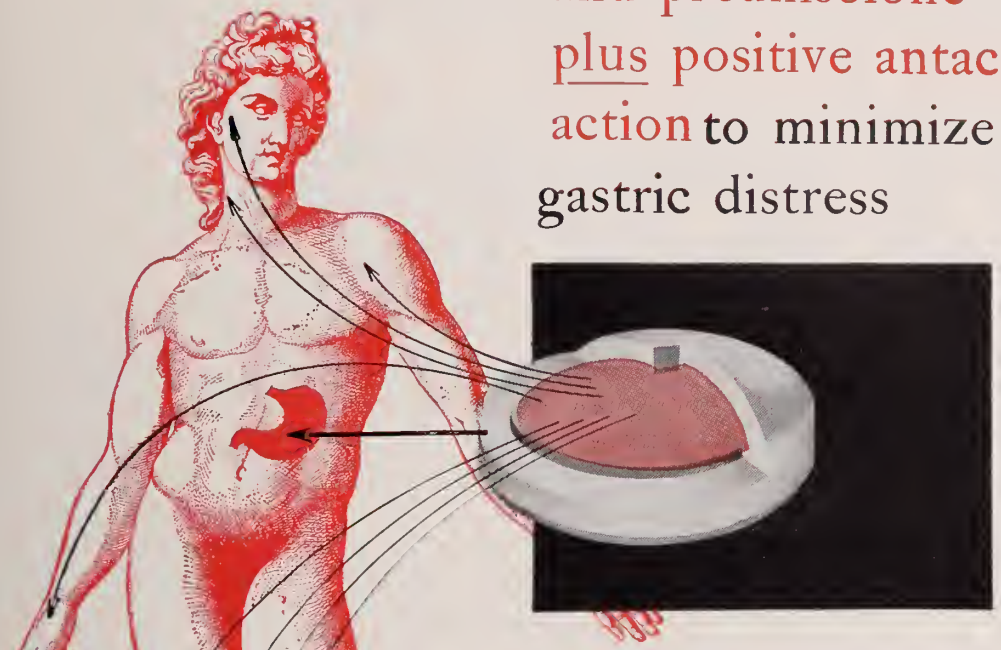
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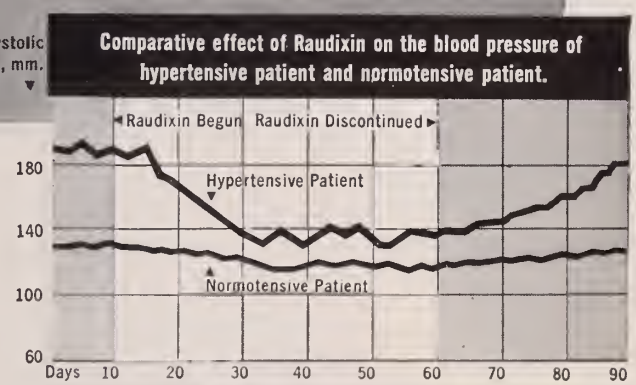
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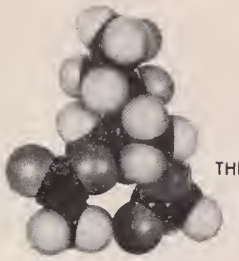
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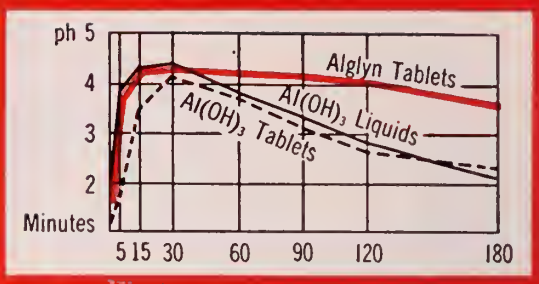
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2. Hammarlund, E.R. and Rising, L.W.: J. Am. Pharm. Assoc., Scientific Edition, 38:586, 1949.

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Medical Aspects of Jaundice

GEORGE H. GARMANY, M.D.
TALLAHASSEE

In this paper only basic principles will be discussed, and the more important causes of jaundice will be mentioned. The place of liver function tests as it relates to liver physiology and the diagnosis and management of jaundice will be discussed. If this seems to be an oversimplification, it is hoped that what is lost in that direction will be compensated for in a better presentation of the more basic aspects of jaundice.

A classification of jaundice based on the stage at which bilirubin is accumulated during the process of excretion seems useful. Many classifications with minor variations can be found. One of the most useful, and what might be called the Oppenheim classification, will be given.

Three Main Types

The first type, prehepatic jaundice, can be divided into hemolytic and nonhemolytic. In this type there is no demonstrable disease of the liver, and the jaundice is due to an increased production of bilirubin or possibly to an increased threshold for excretion of bilirubin due to some type of hepatic cell dysfunction.

The hemolytic type of prehepatic jaundice may present itself in the well known clinical picture characterized by splenomegaly, increased red cell fragility, abnormal rouleau formation with absence of positive evidence of liver cell damage or biliary obstruction. Among other hemolytic disorders are malaria, sickle cell anemia, Cooley's anemia, erythroblastosis fetalis, and blood transfusion reactions.

The nonhemolytic type of prehepatic jaundice is less familiar and has been called familial cholemia, familial nonhemolytic jaundice and constitutional hepatic dysfunction, among other names. There is no splenomegaly, evidence of red blood cell destruction, or abnormal rouleau formation, and the results of tests for hepatic function or obstruction are either normal or only slightly abnormal.

Closely allied to this type is a disorder known as Dubin-Johnson disease, which, like constitutional hepatic dysfunction, runs a benign course over many years, usually gives equivocal findings when liver function tests are performed, and when studied by needle biopsy shows the deposition of an unidentified pigment in the parenchymal cells.

The second type of jaundice might be called the hepatic type and this further subdivided into hepatocellular and hepatoductal, and these further into acute and chronic types. In this type it is the parenchymal cell or the intrahepatic bile capillary which is affected. The designation hepatocellular or hepatoductal might be used depending upon which element of the liver is most affected.

The third main type of jaundice might be called the posthepatic type and might be divided into complete and incomplete obstruction.

Liver Physiology and Liver Function Tests

It might be well to review briefly the physiology of bile production and excretion and to discuss the liver function tests as they apply to liver physiology in the diagnosis and management of jaundice.

Bilirubin is derived from hemoglobin. Hemoglobin is made of an iron-containing pigment, porphyrin, and a protein, globin. Aging erythrocytes are destroyed in the reticuloendothelial system of the bone marrow, spleen and Kupffer's cells of the liver, and iron is removed. The resulting iron-free compound is bilirubin globin. This is transported to the parenchymal cells of the liver, where bilirubin is separated from globin and the bilirubin is excreted in the bile as sodium bilirubinate.

Most of the bilirubin in the colon is reduced to urobilinogen, a colorless compound which is readily oxidized into an orange-yellow pigment, urobilin, which is partially responsible for the

Read before the Northwest Medical District Meeting, Pensacola, Oct. 14, 1955.

brown color of the stool. A part of the urobilinogen is reabsorbed into the blood stream by way of the portal vein, where a part is reconverted into sodium bilirubinate and the remainder enters the hepatic vein and is excreted through the kidney as urobilinogen. Urobilinogen then can occur in the urine only if bile is excreted into the bowel. It would be decreased in amount proportionate to the degree of biliary obstruction and increased if the fecal urobilinogen were increased, as in the case of increased blood destruction with no biliary obstruction.

The physiology of the liver and the liver function tests are discussed jointly so that their significance may be better understood. Obviously, the meaning of liver function tests cannot be properly evaluated unless one understands why he is performing the tests and what the results mean. Somewhat over 40 functions of the liver have been listed and probably more liver function tests devised. All of these may be valuable at times, but only the more common and practical will be discussed.

The liver's role in the storage and synthesis of carbohydrate is well known. In severe hepatocellular disease abnormally low blood sugars might be found in periods of starvation, yet abnormal blood sugar tolerance curves might be found if the carbohydrate meal is fed due to the liver's inability immediately to convert carbohydrate to glycogen and store it in the liver. The galactose tolerance tests is the most frequently used test to determine the liver cell's ability to handle sugar. This material apparently has no renal threshold; that is, it is not reabsorbed through the tubules of the kidney, and any galactose excreted in the urine represents inability of the liver to convert and store this carbohydrate. An excess amount of sugar excreted in the urine is indicative of hepatic cell disease, and this test would not give positive results in obstructive jaundice unless the disorder had gone on long enough to bring about also some degree of parenchymal cell damage.

The liver stores protein and synthesizes albumin, fibrinogen and globulin. Low serum proteins and the disturbance of the albumin-globulin ratio might indicate parenchymal disease. The precipitation and flocculin tests, namely cephalin and thymol, are tests indicating disturbance in this function and will give positive results in parenchymal cell disease and not in posthepatic obstruction unless, as stated, the disease has gone on long enough to bring about hepatic cell damage. The liver synthesizes all the serum albumin and some of the globulin.

Also the liver plays a large part in fat metabolism. It synthesizes and esterifies cholesterol and produces ketone bodies. It synthesizes and stores fat. In addition, it excretes cholesterol through the bile passages. In obstructive jaundice there is usually an elevation of the total cholesterol, whereas in severe hepatocellular disease there is a pronounced fall in the cholesterol esters due to the parenchymal cell's inability to esterify cholesterol. Other factors of course influence the blood cholesterol level.

The liver stores the erythrocyte maturing factor, which is one element in the production of pernicious anemia. It stores iron and copper and forms heparin and prothrombin, the latter being formed in the liver from vitamin K, which is absorbed from the bowel. Bile, in the presence of bacteria in the colon, produces vitamin K. If no bile enters the bowel, no vitamin K is formed, and, on the other hand, in severe hepatic cell damage even though normal amounts of vitamin K may be formed and absorbed, the parenchymal cell cannot convert this vitamin K into prothrombin. These facts are made use of in testing the liver cell's function and in distinguishing prothrombin deficiency due to posthepatic obstruction, in which no bile enters the bowel, from hepatocellular disease in which the hepatic cell cannot produce prothrombin from vitamin K even though an adequate amount is being absorbed from the bowel. If vitamin K is given parenterally in obstructive jaundice, the relatively undamaged liver cell quickly produces prothrombin, whereas the severely damaged liver cell cannot produce prothrombin from parenterally given vitamin K and there will be little or no change in the prolonged prothrombin time after its administration. Other blood-forming functions may be disturbed and be manifest as a macrocytic hyperchromic anemia, which is not due to failure of storage of the erythrocyte maturing factor and is unresponsive to liver extract and vitamin B_{12}.

The liver inactivates estrogens which are secreted even in the male, and in severe hepatocellular damage, especially when chronic, this function is inadequate. One sees enlarged breasts, loss of body hair, feminine distribution of hair, testicular atrophy and spider nevi, all of which are attributed to excess estrogen activity due to the liver's failure to inactivate estrogens.

The excretory function of the liver is well known. It excretes bile acids, bile pigment, alkaline phosphatase, cholesterol, bacteria and thyroxin. The liver also excretes nonmetabolic products, and this fact is made use of in the various excretion tests, such as the bromsulphalein test. Most of the excretion tests do not distinguish between hepatocellular dysfunction and posthepatic obstruction. The alkaline phosphatase is an exception since alkaline phosphatase is excreted through the bile ducts and not dependent upon the parenchymal cell. An elevation of the alkaline phosphatase above 13 Bodansky units is considered to be indicative of obstructive disease unless such diseases as Paget's disease of bone, infantile rickets, hyperparathyroidism or metastatic cancer of the bone are present. This is an extremely important test in distinguishing between hepatocellular and posthepatic obstruction. The van den Bergh test distinguishes between hemolytic and hepatic or posthepatic obstruction. If the indirect reading of the van den Bergh test is high, the elevation is due to the pigment bilirubinglobin, which is a breakdown product of hemoglobin and is not excreted either through the liver cell, bile capillary or kidney, and is elevated only with increased hemoglobin destruction. An increase in the direct reacting bilirubin would indicate the liver's inability to excrete this product, but would not localize the point of obstruction.

This discussion of liver physiology and function is of necessity brief. All liver function tests have a place, but do not relieve the physician of his clinical consideration of the patient. Needle biopsy of the liver is also a valuable diagnostic aid if properly carried out, though it is never an entirely harmless procedure.

Clinical Considerations

Given a case of jaundice then, some orderly method of approach should be followed. The history and general consideration of the patient should come first. It is not possible always to order a battery of liver function tests and come up with the correct answer.

Age is important. Erythroblastosis fetalis occurs soon after birth, as does familial hemolytic icterus at times, though the latter may have its beginning late. Both of these are prehepatic types of jaundice. Hepatocellular jaundice can occur at any age, but statistically is more frequent before the age of 40. The older one gets, the more likely he is to have stone, malignant disease and cirrhosis.

Sex does not help much, though males predominate in the chronic hepatocellular portal cirrhosis and females predominate in the posthepatic jaundice caused by stone.

Jaundice immediately following transfusion is of the hemolytic type. If it follows two to six months after the patient receives any blood product or even needle puncture, serum hepatitis is to be suspected.

It is important to inquire whether or not the patient has received any drug which could possibly be a factor, whether or not there has been any accidental contact with some chemical encountered in industry, contacted accidentally or given therapeutically, and whether or not there are any other cases of jaundice in the family or community. Drugs may cause damage either to the parenchymal cell or to the intrahepatic bile ducts.

Fever is usually present at the onset of either hepatocellular or obstructive jaundice. High fever and chills usually indicate a severe cholangitis due to posthepatic obstruction with infection. Pylephlebitis and amebic hepatitis must be remembered.

Itching occurs in hepatocellular jaundice, but is usually mild. If it is severe and intractable, it is often due to complete obstruction by stone, malignant disease, or stricture.

Nausea and loss of appetite usually do not occur in prehepatic jaundice, but almost invariably occur with the hepatic and posthepatic types. Patients with jaundice of an hepatic or posthepatic type usually have a poor appetite and loss of weight is common, though in the presence of portal cirrhosis this loss might be masked by accumulating ascites. The prognosis in jaundice with known or strongly suspected portal cirrhosis is serious.

Abdominal pain may occur during crises of hemolytic jaundice, and the tendency to formation of gallstones and bile thrombi in the smaller bile passages in patients with hemolytic jaundice must not be forgotten. These patients occasionally present both prehepatic and posthepatic obstruction problems.

Pain in the liver itself is caused either by infection with peritonitis or by rapid enlargement of the liver with stretching of the liver capsule. In hepatic jaundice pain in the right upper quadrant of the abdomen and in the right flank is common and may be so severe as to resemble an acute surgical condition in the abdomen. It is usually described as being aching in character, whereas

the pain in gallstones is usually more colicky. There may or may not be pain when carcinoma of the pancreas is present. The pain may be epigastric, in either upper quadrant of the abdomen, or referred to the back and is characteristically worse during the night and during recumbency. Venous thromboses are common with carcinoma of the pancreas.

It is important to know whether or not jaundice has occurred before and when, since recurrent biliary obstruction is common and the possibility of relapsing hepatocellular jaundice must be kept in mind. An insidious, painless, unremitting jaundice brings to mind carcinoma of the pancreas or ampulla of Vater. Absence of bile in the duodenal contents, if constant, would of course have great significance and would indicate total obstruction. Blood in the duodenal contents might strongly suggest carcinoma of the ampulla of Vater. Frank gastrointestinal hemorrhage occasionally occurs with carcinoma of the head of the pancreas. Persistent absence of bile in the stool would have the same significance as its persistent absence in the duodenal drainage, and absence of urobilinogen in the urine also would have the same meaning.

Splenomegaly occurs in hemolytic jaundice, malaria, sickle cell anemia and other conditions and in portal hypertension from any cause. Generalized lymphadenopathy may occur in viral hepatitis or infectious mononucleosis, or might represent malignant metastases or lymphomatous infiltrations, and biopsies of these glands might be indicated at times. Familial hemolytic icterus, malaria, Mediterranean anemia, and blood hemolysis due to infection or chemicals might be mentioned for further consideration of hemolytic jaundice. These diseases, however, need not be discussed individually.

By far the greater number of cases of jaundice which are of interest from a medical standpoint result from hepatocellular or hepatoductal disease of an acute or chronic nature. Diseases included in the hepatocellular type are the all too familiar infectious hepatitis and homologous serum jaundice, Weil's disease, yellow fever, septicemia, lobar pneumonia, infectious mononucleosis and others. A long list of drugs and chemicals which are used either as therapeutic agents or with which the patient may come in contact accidentally or encounter as industrial hazards may cause the same picture. In these diseases it is almost entirely the parenchymal cell which is involved.

The hepatoductal form of jaundice involves the intrahepatic and extrahepatic bile ducts. It may occur without obvious reason and may follow viral hepatitis or the use of arsenicals, gold, thiouracil, sulfonamide and, more recently, Thorazine. Normal or almost normal reactions to tests for hepatic cell function occur, but there is evidence of obstruction to the flow of bile, and it is in this form of the disease that the total serum cholesterol and the serum alkaline phosphatase would be frequently elevated.

Neoplasms such as cholangioma arising primarily from the larger intrahepatic bile ducts may cause this type of picture, as might obstruction due to leukemia, lymphomatous nodules, metastatic nodules, and other conditions. These, again, need not be discussed further.

The chronic form of hepatoductal jaundice or biliary cirrhosis may occur as a primary disease entity or may be accompanied by posthepatic obstruction. In this condition the liver is usually enlarged, the disease runs a rather benign prolonged course for many years, and the end result may be pathologically indistinguishable from portal cirrhosis.

Two Common Causes

It might be in order to discuss a little more in detail two of the most common causes of jaundice. Both of these are classified as viral hepatitis and are designated as SH, or serum hepatitis, and IH, or infectious hepatitis, types, though, as stated, they resemble jaundice due to Weil's disease, yellow fever, infectious mononucleosis and hepatitis caused by drugs and chemicals.

Infectious hepatitis, like typhoid, is a human contact disease. Serum hepatitis can only be contracted by injection with human blood products and not from human excreta. Contaminated syringes and needles can be responsible for both diseases. Both viruses resist ordinary boiling. No method has as yet been devised to detect the presence of virus in blood products. Immune globulin and human albumin are almost free from risk, and immune globulin given at the proper time is an excellent preventive for infectious hepatitis. Storing plasma in liquid form at room temperature causes less infection than either the frozen or lyophilized serum.

How many physicians in their offices, in hospitals and in laboratories are using needles, syringes and blood lancets which are not autoclaved? Mere boiling is not enough. A physician from one of the medical universities of the South

remarked recently that when he got a case of jaundice from a certain county, he not only knew with reasonable certainty that it was a case of serum hepatitis, but he was equally sure from which doctor's office it came.

Infection from the virus of infectious hepatitis or serum hepatitis causes immunity after recovery, but cross immunization does not exist, one disease to the other.

The picture of insidious or rapid onset with symptoms not unlike those of many other acute infections is familiar. It is rare that the diagnosis is made in the preicteric stage unless the patient has been in close contact with patients having infectious hepatitis or has had blood products in the recent past. The onset may resemble a mild upper respiratory or gastrointestinal disease, or even an acute abdominal emergency. Fever, malaise, weakness, anorexia, and nausea and vomiting are among the most common complaints. Jaundice occurs a few days after the onset; it may be mild to severe and may last days, weeks or months. The liver is usually enlarged and tender. The urine is usually bile-stained, and the stool, at least for a while, become acholic. As recovery occurs, the obstruction becomes intermittent, and finally the jaundice clears.

Acute necrosis of the liver, or, as it has been generally called in the past, acute yellow atrophy, is not a disease entity within itself but merely an extension of the hepatocellular inflammation to a degree that produces complete necrosis.

Medical Management

The medical management of jaundice may vary from simple to difficult. In the mild case the patient gets well in spite of disregarding all medical advice and in the severe case may fail to get well, or may show delayed recovery, or the disease may progress to chronic hepatitis in spite of everything that is done. The importance of bed rest and good diet has been emphasized in practically every medical article on this subject. Most authorities advise a high carbohydrate, high protein diet adequate in fat. This sounds good, but actually one sometimes does well to get the patient with liver disease to eat anything at all. The physician must be willing to settle for far less than the ideal theoretic diet.

The place of the so-called lipotropic agents choline, methionine and inositol is somewhat in doubt though it is my belief that most authorities do not put great emphasis on these products, tending to place far more emphasis on adequate feeding and bed rest. Bed rest is advised until activity of the disease has subsided. Most of the articles appearing on this subject dealing with the armed forces' experience with this disease seem to indicate that the most common cause of relapse is return to activity too early. Many authorities believe that the patient should be kept in bed until the serum bilirubin, icterus index and sedimentation rates have returned to near normal and the condition of the patient warrants letting him up. Some take a more liberal attitude.

In a recent article appearing in the Year Book of Medicine, three authors discussed 79 cases of viral hepatitis occurring in members of the armed forces serving in Germany seen two or three years after recovery from hepatitis. These authors stated. "It is impossible to incriminate inadequate rest, poor diet and alcohol in the development of sequelae following viral hepatitis." They listed the symptoms, physical findings and liver function tests of these men seen months or years later, but made no comparison using the criteria when patients were treated more carefully. It was my general impression that the findings were not as good as should be expected if patients were observed and treated more carefully.

Recent articles have appeared which might indicate that the use of Cortone and ACTH is beneficial. The patient's feelings improve, appetite improves, and the reactions to the liver function tests tend to return to normal earlier. Whether this result is due to Cortone or ACTH directly or whether improved nutrition brings about the change is difficult to say. The use of these hormones to tide a patient over a period of acute necrosis could conceivably be life-saving, though some have thought that this therapy merely postpones the inevitable. Constant intravenous glucose drip may be life-saving in severe hepatitis or acute necrosis.

Summary

In summary, liver function tests can be understood only if liver physiology is considered. Clinical evaluation of the patient is more important than a battery of liver function tests, important as the latter may be. Only a few of the more common causes of jaundice are mentioned, and the treatment is discussed briefly.

Box 487.

Wolff-Parkinson-White Syndrome

Report of Case

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A case of Wolff-Parkinson-White syndrome which recently came under my observation is here described. The various aspects of this syndrome are discussed, and its role in the differential diagnosis of heart disease is pointed out.

Report of Case

A 51 year old salesman was examined because of recurrent pain in the left shoulder, which was unrelated to effort and had been present for the past two years. During the past 25 years he had experienced moderate dyspnea upon exertion, and recently had noted the occurrence of bouts of palpitation following the ingestion of a heavy meal. He was informed by his physician that his electrocardiogram revealed the presence of myocardial damage, and was advised to avoid all forms of physical exertion.

Examination disclosed a white man who weighed 192½ pounds; his pulse rate was 66 with regular sinus rhythm, and the blood pressure was 110/80 mm. Hg. in both arms. The chest was clear bilaterally. On examination of the heart, the point of maximal impulse was located within the midclavicular line in the fifth interspace, the heart sounds were of good quality, no murmurs were heard, and the aortic second sound was greater than the pulmonary second sound. Fluoroscopy disclosed a heart of vertical type with normal configuration of the heart chambers and a normal aorta. Urinalysis gave normal results, but a fasting blood sugar test by the capillary method revealed 165 mg. of sugar per hundred cubic centimeters. An oral glucose tolerance test showed high glucose values at the end of two hours with a return to below fasting values at the end of three hours.

An electrocardiogram (fig. 1) presented a pattern typical of Wolff-Parkinson-White syndrome with a short P-R interval, a wide QRS complex, and slurring of the ascending limb in the R wave. The patient was given 0.5 Gm. of Pronestyl every four hours for a period of 48 hours in an attempt to revert the electrocardiographic pattern to one of normal conduction. This experiment, however, did not meet with success, the Wolff-Parkinson-White pattern persisting after the administration of Pronestyl.

Two days later a standard Master two step exercise test was performed, and a tracing recorded immediately after exercise. This effected a definite alteration in the pattern with a prolongation of the P-R interval, a shortening of the QRS period, a disappearance of the slurred ascending limb of the R wave, the inscription of an isoelectric ST segment, and an upright T wave (fig. 2). At this point it was not too difficult to convince the patient that his electrocardiogram displayed a physiologic variation which was compatible with a normal heart.

Comment

The Wolff-Parkinson-White syndrome is most frequently observed in the later decades of life, but may occur in infancy. Ectopic rhythms are frequently associated with this abnormal conduction pattern in the form of paroxysmal auricular tachycardia, paroxysmal auricular flutter, and paroxysmal auricular fibrillation.

This syndrome is characterized by a P-R interval of 0.10 seconds or less, a QRS interval of 0.11 seconds or longer, notching or slurring of the first portion of the QRS complex, the presence of Q_2 and Q_3 waves,[1] depression of the ST segment, and a diphasic or inverted T wave. Patterns of this type often demand differentiation from bundle branch block and myocardial infarction. In the presence of rapid ectopic rhythms associated with this syndrome ventricular tachycardia may be simulated.

In doubtful cases Pronestyl or exercise may be used as a further diagnostic measure. Pronestyl

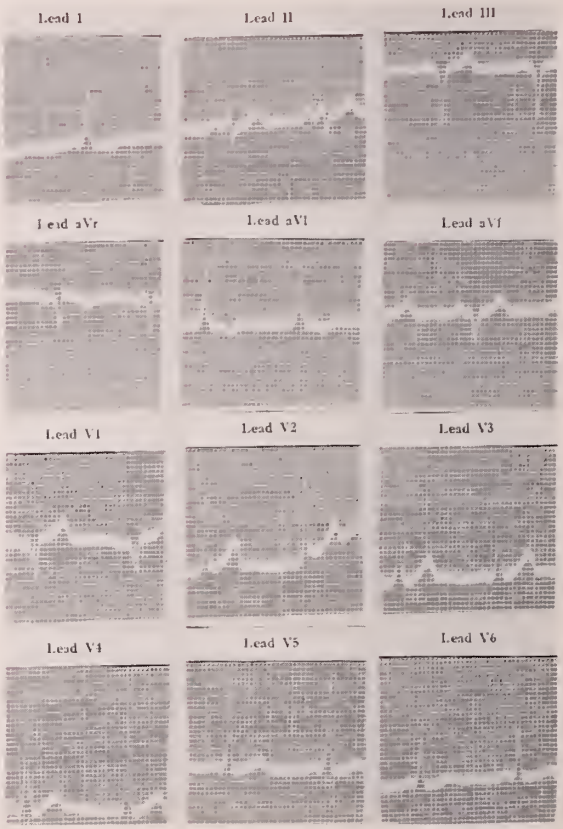


Fig. 1.—Note depressed ST segment and diphasic T wave in addition to a short P-R interval, wide QRS complex, and slurred upstroke of R in lead 1 which occurred at a heart rate of 70.

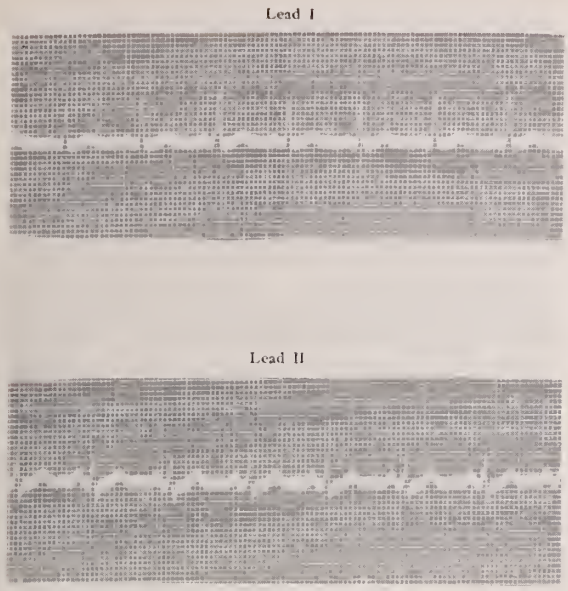


Fig. 2.—Immediately after exercise, at a heart rate of 100 there is a complete alteration of the abnormal pattern in lead 1.

depresses the fibers in the abnormal muscle bundle and may abolish the Wolff-Parkinson-White pattern. Exercise may also produce a return to an auriculoventricular rhythm because beyond a certain critical rate the aberrant pathway is unable to function. The vectorcardiogram may also be used as an aid to differential diagnosis between bundle branch block and the Wolff-Parkinson-White syndrome.

It is now generally accepted that an accessory pathway or bundle of Kent is the responsible mechanism for this syndrome. The short P-R interval is produced by the rapid passing of the auricular impulse to one ventricle through the aberrant pathway while the widened QRS complex occurs when the delayed impulse from the auriculoventricular node passes in an abnormal fashion through both ventricles. Thus, one ventricle becomes activated before the auricular impulse reaches the auriculoventricular node.[2]

The aberrant pathway syndrome carries no clinical import unless it occurs in an impaired myocardium or in infancy. The rapid ectopic rhythm associated with this syndrome adds a burden to an already weakened myocardium, and its occurrence in infancy is associated with refractoriness to treatment.

Summary

A case of Wolff-Parkinson-White syndrome with typical electrocardiographic patterns is reported.

The diagnostic criteria of the syndrome are presented.

The electrocardiographic response to drugs and exercise is reviewed.

The aberrant pathway or bundle of Kent mechanism is discussed.

Also it is pointed out that the misinterpretation of the Wolff-Parkinson-White pattern may be a cause of iatrogenic heart disease.

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420 Lincoln Road.

Florida Medical Association

Eighty-Second Annual Convention

President Milton invites the members to join with him in the activities of the Eighty-Second Annual Convention being held at Miami Beach, May 13-16. Headquarters for the meeting is the Hotel Fontainebleau.

The program, which begins Sunday, May 13, with meetings of the specialty groups, was published in the April issue of The Journal.

Neonatal Mortality in Florida; A Statistical Analysis

Part I: Birthweight, Race and Sex

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AND
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Neonatal survival is affected by a complexity of biologic and socioeconomic factors. Among the more easily recognizable and important of these variables are birthweight, sex, race, plurality, birth order, age of mother, morbid conditions and injuries, previous fetal loss, and attendance at birth by midwife or physician. Study of these variables in relation to each other and an assessment of their importance are essential to the planning of programs aimed at further reductions in neonatal mortality.

These studies will attempt to measure the relationship of birthweight, race, sex, attendance by midwife or physician, and cause of death to neonatal mortality. Single live births and neonatal deaths among single births occurring in Florida in 1953 will be used as the basis for analysis, thus eliminating the effect of plurality. The usually accepted definition of the neonatal period, the first 28 days of life, is employed.[1]

Weight at Birth

In 1953 there were 78,476 single live births recorded in Florida. Weight information was obtained for all but 81 of these births. The relationship of the gestation period (as stated on the birth certificate) to the weight at birth was established for the group under study by a cross tabulation of the certificates containing data on both of these items. On the basis of this relationship, the 81 certificates (which contained gestation information but lacked birthweight data) were allocated to appropriate weight groups.

The distribution of single live births by weight and by race and sex is presented in table 1 and figure 1. Weights have been given both in pounds and in their gram equivalents.

Median Weight

The average (median) weight of each group is shown in the bottom line of table 1. The median is a measure which divides the series of weights into two groups. Half of the infants in the group weigh more than the median and half of the group weigh less.

Within each race category, the average male infant weighed more than the average female. For whites the excess weight of the males was 123 grams (4.3 ounces), and white males weighed 3.8 per cent more than white females. For nonwhites the excess weight of males over females was 112 grams (4.0 ounces) or 3.5 per cent more.

Within each sex grouping, white infants weighed more than nonwhites. For males, the whites weighed 59 grams (2.1 ounces) or 1.8 per cent more on the average, and for females the white babies weighed 48 grams (1.7 ounces) or 1.5 per cent more. Sex is apparently a more important factor in differences in birthweight than is race.

Weight and Prematurity

A weight of 2,500 grams (5 pounds, 8 ounces) or less has been established as a statistical definition of prematurity by the World Health Organization.[1] Ideally, the diagnosis of prematurity should be based on the length of the gestation period and/or clinical evidence of prematurity,

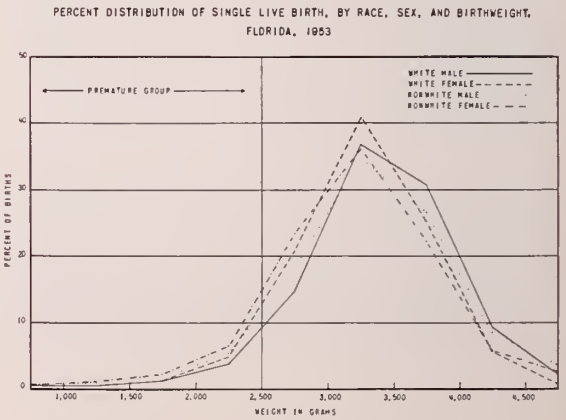


Figure 1.

Prepared by the Bureau of Vital Statistics, Florida State Board of Health, of which Mr. Williams is Director and Mr. Thorner, Chief Statistician.

but this has not been found to be practical because of the difficulties of determining gestation length, the inherent variability of the gestation period, and the difficulties of obtaining on birth certificates accurate diagnoses of prematurity based upon clinical evidence.

As a result of differences in the distribution of birthweights within each race and sex group, the proportion of premature infants (based on the weight criterion mentioned) varies with race and sex. The number and per cent of premature births for each race and sex group in 1953 is indicated by table 2.

Within each race group the males, with higher average birthweights, have a smaller percentage of premature births; and within each sex group the whites, with heavier average weights, show a smaller proportion of premature infants.

Weight Bias

The weight distribution of nonwhite births may be subject to biasing inaccuracies because of the large number of nonwhite births attended by midwives. It is doubtful whether the weighing of infants by midwives is as accurate as the weighing of the newborn in hospitals despite the midwifery training course conducted by the Division of Public Health Nursing of the State Board of Health.

Neonatal Deaths

In 1953 there was a total of 1,499 neonatal deaths of singly born infants for which the Bureau of Vital Statistics was able to locate and match birth certificates. Information concerning birthweight and other characteristics was obtained from the matched birth records. Excluded from the study were 7 neonatal deaths for which no corresponding birth record could be obtained. Of the 7, 3 were "unknown bodies" about which there was insufficient information to make an identification. For the remaining 4, no birth certificate had been filed, and certificates could not be obtained.

Of the 1,499 matched births and deaths, 18 of the birth records did not contain birthweight information. These were allocated to appropriate birthweights on the basis of gestation information.

Neonatal Death Rates

Neonatal death rates were calculated for each specific weight category within each race and sex group by dividing the number of neonatal deaths in the particular weight-race-sex group by the number of births in the corresponding group. These rates stated in units of 1,000 live births are presented in table 3 and figure 2.

From the exceptionally high mortality rate of 839.2 deaths per 1,000 births in the group of infants weighing 1,000 grams or less, the rates fall rapidly with increases in weight until the maturity level of 2,501 grams is reached. The rates fall less rapidly after this point, reaching a minimum of 4.7 deaths per 1,000 births in the 3,501 to 4,000 gram weight group. Slight rises in the neonatal death rates take place progressively with increases in weights above this category. Florida rates are approximately the same as those observed by Shapiro and Unger[2] in their study of national data for 1950.

In comparison with nonwhites, white births tend to be concentrated in the weight groups where the mortality experience is more favorable. A greater proportion of nonwhite births occurs in the extremely high weight group of 4,501 grams

Table 1. — The Distribution of Single Live Births by Race, Sex and Weight, Florida, 1953

Birthweight		Births					Per Cent Distribution				
Pounds and Ounces	Grams	Total	White		Nonwhite		Total	White		Nonwhite	
			Male	Female	Male	Female		Female	Male	Male	Female
All Weights	All Weights	78,476	29,260	27,934	10,679	10,603	100.0	100.0	100.0	100.0	100.0
Under 2 lb., 4 oz.	1,000 grams or less	398	137	138	67	56	0.5	0.5	0.5	0.6	0.5
2 lb., 4 oz. - 3 lb., 4 oz.	1,001 - 1,500	479	153	135	87	104	0.6	0.5	0.5	0.8	1.0
3 lb., 5 oz. - 4 lb., 6 oz.	1,501 - 2,000	1,018	323	314	158	223	1.3	1.1	1.1	1.5	2.1
4 lb., 7 oz. - 5 lb., 8 oz.	2,001 - 2,500	3,744	1,130	1,361	563	690	4.8	3.9	4.9	5.3	6.5
5 lb., 9 oz. - 6 lb., 9 oz.	2,501 - 3,000	14,528	4,326	5,782	1,936	2,484	18.5	14.7	20.7	18.1	23.4
6 lb., 10 oz. - 7 lb., 11 oz.	3,001 - 3,500	29,678	10,754	11,348	3,732	3,844	37.8	36.8	40.6	34.9	36.3
7 lb., 12 oz. - 8 lb., 13 oz.	3,501 - 4,000	21,245	9,040	7,010	2,847	2,348	27.1	30.9	25.1	26.7	22.1
8 lb., 14 oz. - 9 lb., 14 oz.	4,001 - 4,500	5,877	2,761	1,596	908	612	7.5	9.4	5.7	8.5	5.8
10 lb., 15 oz. - and over	4,501 grams or more	1,509	636	250	381	242	1.9	2.2	0.9	3.6	2.3
Average (median)	weight (grams)	3,322	3,399	3,276	3,340	3,228					

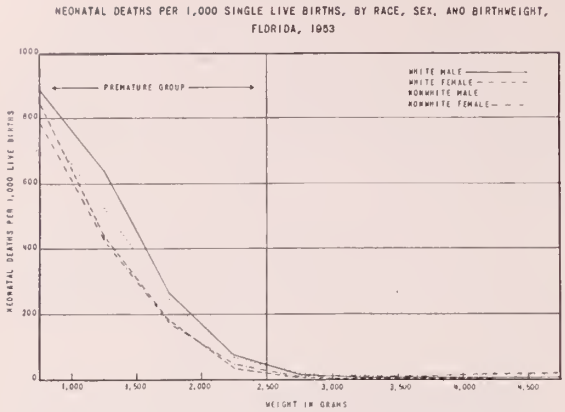


Figure 2.

and over, and below the maturity level of 2,5 grams where the death rates are higher.

Effect of Different Weight Distributions

An indication of how much of the race and sex difference in neonatal mortality rates may be attributed to factors other than weight differences may be gained by a comparison of the rates for specific weight categories. A summary measure, the weight adjusted rate, has also been calculated. The weight adjusted rate is a measure which indicates what the rates for the different race and sex groups would be if all births within these groups had the same percentage distribution of birthweights. In calculating these weight adjusted rates, the weight distribution of all single live births was used as a standard.

Sex Differences

In almost every weight group, females have a more favorable mortality experience than do males of the same race. Exceptions are the nonwhite rates for 3,501 grams and above.

Among whites, the unadjusted neonatal death rates are 19.5 deaths per 1,000 births for males and 14.0 for females. After adjustment for differences in weight distribution, the rates are 21.9 for males and 14.8 for females, indicating a greater disparity in survival (weight for weight) than is apparent from an examination of the unadjusted rates.

Among nonwhites the unadjusted rates are 28.1 for males and 22.6 for females. The rates after adjustment are for males 25.4 and for females 18.8.

Differences in the weight distributions of males and females of the same race must be regarded as wholly biologic in origin. No ready explanation is available for the better survival experience of females over males other than the possibility of greater physical maturity of females at comparable weights. Research into possible causes of the difference should prove of interest.

Race Differences

A comparison of the specific mortality rates by race presents an interesting contrast. For the lowest weight classifications and up to weight group 2,501-3,000 grams, mortality rates among nonwhite males are lower than among white males. For the more frequent or "normal" weight and in the highest weight categories, nonwhite male rates exceed those of white males. This is essentially the situation for the female rates, except that the nonwhite rates begin to exceed the white at weight of 2,001-2,500 grams and above.

The excessive nonwhite mortality in the normal and higher weights is sufficiently great, however, to cause the unadjusted nonwhite rates to exceed the white for the same sex. A pattern of differences in neonatal mortality rates by race similar to these was observed by Shapiro and Unger[2] in their study of national data.

A possible explanation of the lower neonatal mortality rates among nonwhites in the lower weight groups may lie in the higher fetal death rates in this group. In 1953, there were 14.4 stillbirths reported among whites for every 1,000 live births. Among nonwhites the rate was 32.7 per 1,000 live births. It is possible that the excess of nonwhite fetal deaths reduces the neonatal mortality in the lower weight groups. Underreporting of low birthweight neonatal deaths among nonwhites may also possibly account for the apparently more favorable survival experience of nonwhites at the lower birthweight levels. The degree of underreporting, if any, is unknown.

That much of the difference in neonatal mortality rates between whites and nonwhites is accounted for by differences in weight distribution may be seen by an examination of the adjusted

Table 2. — Total Single Live Births, Premature Births,* and Per Cent of Live Births Which Were Premature, by Race and Sex, Florida, 1953

Race and Sex	Births	Premature Births	Per Cent Premature
All Births	78,476	5,639	7.2
White males	29,260	1,743	6.0
White females	27,934	1,948	7.0
Nonwhite males	10,679	875	8.2
Nonwhite females	10,603	1,073	10.1

*Infants weighing less than 2,501 grams at birth.

and unadjusted rates. For males, the unadjusted rates are: white 19.5, nonwhite 28.1. The adjusted rates are: white 21.9, nonwhite 25.4. For females the unadjusted rates are: white 14.0, nonwhite 22.6. The adjusted rates are: white 14.8, nonwhite 18.8.

After adjustment for weight distribution differences the rates by race are in closer agreement, but a considerable difference in rates attributable to other factors still remains.

Previous studies have suggested that differences in weight distributions by race are biologic in origin, and that nonwhite infants of a particular weight and sex are more fully matured than white infants of a comparable weight and sex.[3] Other authors[4] have suggested that weight differences are the result of the lower socioeconomic status of nonwhites and of the comparatively poor nutrition and prenatal care received by this group.

If the difference in weight distributions is the result of socioeconomic factors, improvement of social and economic conditions among nonwhites should bring about a greater comparability of birthweight distributions between whites and nonwhites and a consequent lowering of the unadjusted nonwhite neonatal death rates. Such a change may now be taking place, and studies of this type made at widely separated time intervals will tend to confirm or contradict this theory.

If the difference is of biologic origin, improving social conditions should not effect a change in the weight distribution of nonwhite births, and improvement in neonatal death rates among nonwhites may be expected to occur solely within weight categories due to the elimination of specific causes of mortality, rather than to result from a general shifting of the weight pattern of nonwhites.

Summary and Conclusions

Male infants weigh more on the average at birth than females, and white infants weigh more than nonwhites. White births tend to be concentrated in the weight groups where survival chances are more favorable.

The lowest neonatal mortality experience is found in the group of infants weighing 3,501 to 4,000 grams (7 pounds, 12 ounces to 8 pounds, 13 ounces). Death rates are inversely related to weight below this weight level, rising sharply in the weight groups below the maturity figure of 2,501 grams.

Crude neonatal death rates of females are lower than the crude rates for males of the same race. When differences in the weight distributions between males and females are considered, the survival experience of the females is even more favorable than that indicated by the crude rates.

Crude white neonatal death rates are lower than nonwhite rates for infants of the same sex. Some of the difference in the crude neonatal mortality rates is accounted for by differences in the distribution of birthweights between the races. After adjustment for weight differences, however, a considerable differential in the death rates attributable to other factors remains.

The racial differences in birthweight distributions may be the result of either biologic or socioeconomic factors. Continued studies may resolve this question.

Table 3. — Neonatal Deaths, Weight Specific and Weight Adjusted Death Rates per 1,000 Live Births By Race and Sex, Single Live Births, Florida, 1953

Weight in Grams	Deaths					Rates				
	Total	White		Nonwhite		Total	White		Nonwhite	
		Male	Female	Male	Female		Male	Female	Male	Female
1,000 grams or less	334	121	116	53	44	839.2	883.2	840.6	791.0	785.7
1,001 - 1,500	248	98	59	46	45	517.8	640.5	437.0	528.7	432.7
1,501 - 2,000	221	85	57	39	40	217.1	263.2	181.5	246.8	179.4
2,001 - 2,500	200	82	48	39	31	53.4	72.6	35.3	69.3	44.9
2,501 - 3,000	174	70	40	37	27	12.0	16.2	6.9	19.1	10.9
3,001 - 3,500	174	59	42	52	21	5.9	5.5	3.7	13.9	5.5
3,501 - 4,000	99	39	23	20	17	4.7	4.3	3.3	7.0	7.2
4,001 - 4,500	37	12	5	9	11	6.3	4.4	3.1	9.9	18.0
4,501 grams or over	12	3	—	5	4	8.0	4.7	—	13.1	16.5
All weights (crude rate)	1,499	569	390	300	240	19.1	19.5	14.0	28.1	22.6
Weight adjusted rate						19.1	21.9	14.8	25.4	18.8

At very low weights, the survival experience of nonwhites is more favorable than that of whites. This may be the result of a greater incidence of fetal mortality among nonwhites and/or the underreporting of neonatal deaths in this group. The lower mortality rates of nonwhite infants in the lighter weight categories suggests that a combination measure including fetal deaths and neonatal deaths related to total live births and fetal deaths (the perinatal death rate) may be of considerable value as a statistical measure in the future.

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Box 210.

Successful Treatment of Bacterial Endocarditis Due to Streptococcus Faecalis

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A review of the literature over the past several years makes it obvious that the treatment of enterococcal endocarditis is difficult. Numerous combinations of drugs have been used, most of which have been only partially successful. The combination used in the case reported here had been suggested previously, but the dosage had not been standardized. The treatment used in this case with successful outcome is described.

Report of Case

C. K., aged 32, a Negro housewife, first consulted me on Aug. 31, 1953, complaining of a headache. She stated that approximately six week before, she had had a spontaneous miscarriage followed by fever which required her to stay in bed for about two days. After she was up and about, her strength came back slowly. She had consulted several doctors, who gave her symptomatic treatment and referred her to me for further examination.

The patient had five normal children, living and well, whose births had been normal. No history could be elicited suggesting any type of heart disease or heart murmur. There was no record of her deliveries in any hospital so that I was unable to determine accurately whether or not a murmur had been present. She had never been sick, and there was nothing in her family history of importance.

Physical examination revealed an apprehensive Negro woman of light-tinted skin, pale and anxious. The blood pressure was 90 systolic and 60 diastolic in both arms, the weight was 117 pounds, and the temperature was 100.2 F. The throat was slightly red, but there were no ulcerations and no enlarged glands. A grade III apical systolic murmur was present, which was not transmitted in any direction. There was no cardiac enlargement. An electrocardiogram taken at this time revealed a rate of 112 with regular sinus rhythm and a somewhat prolonged P-R interval of .20 seconds.

There was some improvement on symptomatic treatment. The temperature remained elevated, however, and laboratory investigation became necessary later. Blood cultures made at St. Mary's Hospital in West Palm Beach showed on three successive days a positive culture of Streptococcus faecalis. A blood count made at the same time revealed a white cell count of 5,300 with 26 stab forms, 46 segmented forms, 25 lymphocytes and 3 monocytes; the red cell count was 3,470,000 with a hemoglobin estimation of 10.5 Gm.

After reviewing the literature and making necessary arrangements locally for the patient to be treated at home by a visiting nurse, I designed a schedule by which she was to receive 1.5 million units of Penicillin O Potassium (Cer-O-Cillin) twice a day and 500 mg. of oxytetracycline (Terramycin) four times a day. The program was to be continued for six weeks.

The patient stayed at home in bed, had few complaints and experienced no reaction of consequence to either drug during the period of treatment. At the end of the recommended time she was sent to the hospital by ambulance for a blood culture and blood count. Examination of the blood showed a white cell count of 4,350 with 9 stab forms, 59 segmented forms, 23 lymphocytes and 2 monocytes; the red cell count was 2,900,000 with a hemoglobin estimation of 8.5 Gm. Because of the reduction in the red cell count and the neutropenia she was given two pints of blood at the Pine Ridge Hospital, after proper cross matching. Three blood cultures then were made on successive days; all were negative at that time, and repeated cultures have remained negative.

The patient was allowed to get up and about and she carried out her normal household duties as her strength permitted. In February 1954 I finally persuaded her to return to the hospital for a series of three more blood cultures. They also were reported negative.

In July 1954 the patient considered herself to be pregnant and came to my office for examination. It was determined that she was about two and a half months pregnant. A therapeutic abortion was performed by Dr. William H. Kirkley of Fort Lauderdale after due process of consultation. He performed a hysterotomy and a Pomeroy sterilization. She had no reaction to the surgery and has been well since.

Comment

In view of the fact that the treatment of bacterial endocarditis due to Str. faecalis has been

especially difficult and the end results have not been encouraging, it was considered desirable that treatment with this combination of drugs be reported in order that it might be of assistance in further care of this type of patient. It is particularly noteworthy that the patient received only one course of treatment, that the blood cultures immediately became negative, and that repeated cultures have remained negative for several months. She gained weight, feels well and has had no further disability. It seems possible that the surgery to which she was subjected following this treatment might have caused a recurrence of the disease since it is usually some type of genitourinary or gynecologic procedure that precipitates this type of infection. It did not do so, however, and the patient recovered well from the hysterotomy and Pomeroy sterilization.

Summary

A new combination and dosage of drugs for the treatment of endocarditis caused by Str. faecalis is reported. One case is presented in which this therapy was employed successfully.

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ABSTRACTS

Clinical Study of a New Tranquilizing Drug: Use of Miltown (2-Methyl-2-*n*-Propyl-1,3-Propanediol Dicarbamate). By Lowell S. Selling,† M.D., Ph.D., Dr. P. H. J. A. M. A. 157:1594-1596 (April 30) 1955.

A recent promising propanediol derivative, Miltown (2-methyl-2-*n*-propyl-1, 3-propanediol dicarbamate), is the subject of a study made on 187 patients and reported here. The drug has a selective blocking action on interneurons. It produces relaxation of skeletal muscles without affecting respiration and other vital functions and also has important effects on the brain.

In summary, the observations and conclusions were: Miltown is a practical, safe, and clinically useful central nervous system depressant. It is not habit-forming. Miltown is of most value in the so-called anxiety neurosis syndrome, especially when the primary symptom is tension. Miltown is also useful in keeping alcoholics sober after withdrawal is completed, and it has much value in accomplishing withdrawal with a minimum of discomfort. Favorable results have also been obtained in neurogenic conditions of the skin, in abdominal discomfort, and in several kinds of headache. Miltown is an effective dormifacient and appears to have many advantages over the conventional sedatives except in psychotic patients. It relaxes the patient for natural sleep rather than forcing sleep.

†Dr. Selling died Jan. 18, 1955.

Rabies Control. By J. Basil Hall, M.D. GP 11:81-85 (April) 1955.

This article presents the story of one Florida community's experience with an outbreak of rabies. The trouble started in Lake County along a 20 mile stretch of highway where some 18,000 people reside and included the towns of Fruitland Park, Leesburg, Tavares and Mount Dora. Prior to the outbreak, there had not been a case of rabies, in man or animal, for about five years. The author, who is Director of the Lake County Health Department, relates how one stray dog brought terror to the community. Before the problem of rabies was brought under control, household pets were sacrificed, many more were vaccinated against rabies, and a number of humans received antirabies treatment. That treatment was never recommended lightly; the potentiality for serious adverse reactions is too great.

Dr. Hall mentions under special considerations that (1) animal rabies, both wild and domestic, is definitely endemic in Florida and should be considered a major public health problem; (2) great reduction in the population of dogs, cats, and wild animals must be accomplished; (3) known, proved and accepted methods should be applied for the control of rabies in dogs; and (4) in handling a dog-bite victim, all scratches and bites should be treated as if inflicted by a rabid animal. He outlines that treatment. His conclusion is that a stray dog, unbefriended and destroyed, ceases to be a problem.

The Differential Diagnosis of Jaundice. By Richard G. Connar, M.D. North Carolina M. J. 16:44-48 (Feb.) 1955.

This author describes and classifies jaundice, discusses the value of an adequate history from the standpoint of age, sex, pain, preicterus, symptoms, pruritis, and urine and stool, considers the role of the physical examination, and evaluates the laboratory tests in the differential diagnosis of this disease. In summary, he concludes that in approximately 90 per cent of all cases of jaundice the cause may be determined by careful correlation of the clinical features with only a few essential laboratory tests. In the remaining cases, needle biopsy or exploratory laparotomy may become necessary to establish the diagnosis. The most informative liver function tests are serum bilirubin, thymol turbidity or cephalin flocculation, alkaline phosphatase, and urine urobolinogen.

In patients over 40 years of age in whom laboratory tests give minimal evidence of hepatic damage, if the jaundice does not subside rapidly within two weeks after its peak, laparotomy should be performed because of the increased incidence of extrahepatic obstruction. In patients under 40 years of age, the same time interval should be adhered to except when the history is strongly suggestive of infectious hepatitis. Limited exploration and direct biopsy of the liver, with the use of local anesthesia, may be more satisfactory than needle biopsy of the liver.

Reflux Esophagitis. By G. Dekle Taylor, M.D. Laryngoscope 65:589-627 (Aug.) 1955.

In this successful candidate's thesis presented to the American Laryngological, Rhinological and Otological Society, Dr. Taylor discusses the subject of reflux esophagitis with regard to anatomy and physiology, pathology, symptoms, diagnosis, etiology as illustrated by specific cases, and treatment. Included also is an extensive review of the literature. His study of this disease and experience in dealing with its manifestations, as demonstrated by the cases reported, indicate the importance of creating an awareness of this entity, which appears to be more prevalent than is generally realized.

After presenting in some detail the anatomy and physiology of the esophagus, particularly of the lower portion, he describes the pathologic changes, symptoms, and diagnosis of reflux esophagitis. He then discusses the etiology of this disease and presents seven cases to illustrate various causes. These cases are typical of postoperative reflux esophagitis, reflux esophagitis associated with duodenal ulcer, reflux esophagitis in association with hiatal hernia and shortened esophagus, and reflux esophagitis secondary to esophageal surgery. There follows a discussion of the medical and surgical management of this disease.

Dr. Taylor stresses the importance of esophagoscopy in the final diagnosis and understanding of this entity. He urges the otolaryngologist to become well aware of the symptoms, the characteristic pathologic changes, and the sequelae of reflux esophogitis. Likewise, he observes that the internist, the surgeon, and the general practitioner all may benefit by familiarity with the various aspects of this disease so that early recognition and remedial measures may combat both the disease and a tendency among physicians to regard its initial manifestations as functional in nature.

A New Modality for Urinary Incontinence in the Adult Male: Preliminary Report. By T. J. Florence and J. E. Kicklighter. Transactions of the Southeastern Section of the American Urological Association, 1954.

The causes of urinary incontinence are here enumerated, and the many methods used to control the incontinence are briefly reviewed. The need for a more satisfactory method of control than any of these methods offer led the authors to devise a urethral prosthesis to be implanted into the distal urethra. It is inserted surgically under regional or general anesthesia. The surgical procedure is described. The 4 patients subjected to this procedure were totally incontinent owing to complete loss of sphincter control either following surgery or following injuries to the spinal cord. It is concluded that this urethral prosthesis offers a new method of controlling urinary incontinence in the adult male which in some respects may prove to be superior to those methods used previously to control this condition, particularly in those patients who do not tolerate the use of catheters, urinal bags or penis clamps. They point out the need for further study by them and others in this field.

Cervical Carcinogenesis, Stress and Adaptation Factors, Regression Studies. By J. E. Ayre. La prophylaxie en gynécologie et obstétrique, vol. I, Conférences et rapports du Congrès international de gynécologie et d'obstétrique, Genève. 1954.

In this paper preliminary discussion of investigations now under way presents certain evidence and new thought which suggest that local stress and consequent cellular adaptation may be intermediary steps in the transformation of cervical epithelial cells from benign to malignant.

There has long been speculation as to the role of chronic inflammation in the production of carcinoma of the cervix. Clinical and epidemiologic factors are presented which substantiate this concept. A hypothesis is introduced suggesting that Selye's stress and adaptation syndrome may fit into the complex picture of cervical carcinogenesis. The leukorrhea of chonic cervicitis, the presence of an estrogen in cervical mucus, and hypoxia resulting from the fibrotic changes of chronic inflammation are presented as "links" in a "chain reaction" of cancerogenesis. It is hypothesized that an "alarm" type of reaction may be a possible mechanism in the regression of certain neoplasms. A promising avenue for further experimental research is suggested.

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Physicians Given Vote of Confidence by the Public

What people like about doctors and what they expect from them was brought into focus recently by a public opinion survey sponsored by the American Medical Association. The object of this survey was to learn what might be needed to improve doctors' services, and from it emerged a revealing picture of what the average American thinks of his doctor and doctors in general. It also disclosed that doctors are more critical of themselves than are their patients.

The results of this study show that the layman today frankly wants "sympathy, patience, and understanding" rather than "guaranteed cures" and "wonder drugs." He is not critical of the physician's personality or ability; rather, what he criticizes is a matter of time and economics.

Five out of six, or 82 per cent, of the general public indicate that they have a personal or family physician — one whom they usually call first. The highest percentage (90 per cent) is reported in the rural areas and the lowest (73 per cent) among nonwhites. Dwellers in medium and large cities, and also Westerners, report fewer family doctors than the average. It appears that the concentrated efforts by the medical profession to encourage people to secure a personal physician before illness strikes have been most successful. Reasons for changing doctors are that the patient moved, or the doctor moved, entered military service, became ill, retired or died. Rarely does the patient lose confidence in his doctor (5 per cent), find a better doctor (2 per cent), or disagree with his diagnosis or treatment (1 per cent).

Almost universally, people like and respect their personal or family physician. Ninety-six per cent replied unequivocally in the affirmative and only 1 per cent in the negative when asked if they like their own doctor as a person. Between 88 and 98 per cent hold high opinions of his intelligence, capability, dedication to humanity, and personal interest in patients. The percentages in the critical category are gratifyingly low: 5 per cent of those with a personal physician agree that he thinks he is better than other people; 6 per cent that he is not as dedicated to serving mankind as he should be; 5 per cent that he is too quick to recommend operations; 15 per cent that he is not frank enough about their illnesses; and

15 per cent that he keeps patients waiting longer than necessary. A mere 16 per cent agree that he charges too much; 10 per cent are of the opinion that he plans to get rich quickly; 13 per cent think that his charges have gone up faster than other living costs; 19 per cent agree that he is hard to reach for emergency calls; 23 per cent believe that he has the idea that he is always right; and 13 per cent hold that he makes too much money compared with his patients.

Most people tend to think of their doctor as "someone special" and believe that today, even more than 20 years ago, it is important to choose the right man. At least 85 per cent say he is different from other doctors. They cite his personal interest, sympathy, kindness, competence, intelligence, friendly personality and manner, frankness and honesty most frequently as the qualities which differentiate him from other doctors. Also mentioned are his availability when needed, his patience, understanding, willingness to take enough time with patients, his low fees and his uncomplaining acceptance of payment delays.

Certainly the attitudes of the public about doctors are far more favorable than unfavorable. The vast majority deny most of the frequently voiced complaints about doctors when speaking of their own, particularly about long waits in medical offices, refusal to respond to emergency calls, doctors' "know-it-all" attitudes, their tendency to talk in "high-falutin' terms," and their cold and impersonal attitudes. Nevertheless, many people accept certain charges against doctors as a group which they reject for their own physicians.

One of the most important revelations of the survey is the evidence that there is a striking difference between the good opinion people have of their own doctors and their impressions of doctors in general, whom they do not know personally. The percentages for complaints rise 20 to 30 per cent for doctors in general above those for the personal physician. Conscientious doctors will want to examine this peculiar quirk. Perhaps this wide divergence of opinion is founded merely on exaggeration incident to sympathy seeking, a human frailty against which the physician has no recourse other than to continue trying to please as many patients as much as possible. The agency making the survey, however, suggested a reason which, if valid, should give doctors pause for thought. According to that source, "it seems evident that the individual doctor needs to form a better opinion of his colleagues and to convey that opinion to his patients. If he himself helps create derogatory impressions of other doctors, he thwarts the public relations efforts of his profession."[1]

A sidelight here is that the only area in which the doctor's self-esteem outdid the public's was on the question of fees. A revealing disclosure was that doctors who were questioned seemed to expect the public to be critical of fees; instead, the public itself was much more concerned about personal qualities and service. It would appear then that the doctor is defending himself against an attack that is not being made and at the same time letting down his guard where the charges are being hurled.

The public has gained a realistic idea of the number of years of training required to practice medicine, estimating from seven to 11 years. One fourth agreed that doctors never retire and nearly that many gave 65 to 69 years as the average retirement age. The public's median estimate of their own doctor's work week is 64 hours, with 12.5 per cent of this time given to charity work, with 63 hours and 12 per cent as the public estimate for doctors in general. These figures are unusually close to the doctors' own estimates of 62.5 hours and 13 per cent charity.

The public's estimate that about one third of all doctors are specialists agrees closely with the actual proportion of full time specialists (36 per cent), and less than half of the public is critical of this trend. Also, the public does not necessarily consider specialists to be more capable than general practitioners are. Belief that a doctor shortage exists is not as prevalent as might be expected. About half of the public but only a fifth of the doctors think there are not enough doctors in the United States. Neither group thinks the shortage is self-imposed by the profession.

The complaints of doctors against themselves run as much as 20 per cent above the public's. They are quicker than their patients to agree that they do not give as much time as they would like, and on lack of availability for emergencies. They agree closely with the public, however, on estimates of their capability, intelligence and willingness to accept medical advances and they feel most appreciated for competence, sincerity, and healing abilities.

Only about half who answered have any knowledge of the American Medical Association and they remember chiefly general publicity, drug research, conventions, and opposition to government medicine. Neither the laity nor physicians are particularly critical of the A. M. A. political ac-

tivities. One fourth of the public and half of the doctors consider this activity to be "about the right amount;" 15 per cent of the public and 16 per cent of the doctors regard it as "too much;" and 4 per cent of the public and 19 per cent of the doctors favor more such activity.

Family doctors may congratulate themselves that they are held in high esteem by their patients, and doctors in general that they are looked upon favorably although not as favorably as are personal physicians. Nevertheless, the criticisms exclude no doctor. When the public refers to "other doctors," it means all doctors, with no individual excluded, however exemplary his behavior. The facts brought to light by the survey are simple and clearly stated; from them every physician is privileged to draw his own conclusions. The wise doctor will examine the report[2] and then point a questioning finger at himself.

1. National Pulse Beat, J. A. M. A. 160:470 (Feb. 11) 1956.
2. Public Opinion Survey About Doctors, J. A. M. A. 160:471-472 (Feb. 11) 1956.

Does the Doctor Want His Child to Become a Physician?

Do the rewards of practicing medicine compensate for the hardships? How the average physician feels about his profession is in large measure reflected in his advice to his children about a professional career. Would he have them follow in his footsteps?

Bent on finding the answer to this question, an enterprising drug publication set out to discover the doctor's attitude by conducting a nationwide survey.[1] The inquiry disclosed that well over half — almost 60 per cent — of the physicians in this country would advise their sons to become physicians. The altruistic motive predominated. Chief among the reasons given was satisfaction in helping humanity. Other reasons mentioned were satisfaction in doing something worth while, financial security and social prestige.

Physicians not willing to advise their sons to enter medicine were of the opinion primarily that the son should decide for himself, thus manifesting the traditional individualistic spirit of the practitioner of medicine. They stressed also the need for a strong desire to study medicine, the lack of sufficient time with one's family, insufficient financial compensation, the trend toward socialized medicine, and overwork for a public too demanding.

Approximately 15 per cent of physicians, the survey indicated, want their daughters to become physicians. They gave satisfaction in helping humanity and a mentally rewarding occupation as the principal reasons. The large proportion unwilling to advise their daughters to practice medicine were of the opinion that woman's place is in the home. They also thought that women are physically and emotionally unsuited for medicine and that medicine is too demanding and strenuous for women.

Thus the results of this study indicate that a majority of physicians would advise their sons to follow in their footsteps. They admit that the practice of medicine today has many drawbacks, but they find that the rewards far outweigh the hindrances and provide ample compensation. A Florida physician put it this way: "Yes. If he felt that he had an honest call to help humanity regardless of time and money, it would be the only thing he would be happy doing." On the other hand, from a doctor in Ohio came this comment: "No. I would hesitate to advise him regarding any profession and particularly one requiring the hours and discipline of medicine."

With regard to advising a daughter to practice medicine, a New York doctor was emphatic: "Yes. Best place on earth to help humanity and be happy." A practitioner in Massachusetts replied: "Yes. If she desires it, I would have her become a physician — women have a place in medicine." A Virginia physician, however, took the opposite view: "No. The frustrations and irregular hours would interfere with the exercise of her natural talents and gifts." Also replying in the negative was a practitioner in Delaware who with many others liked "the old-fashioned view that a normal woman's destiny is to become a wife, mother, and homemaker."

Perhaps the best advice a physician-father has to offer his son or daughter about following in his footsteps professionally takes the form of an example. If he seeks always to represent the best in medicine, to uphold its basic principles and lofty ideals, and at the same time essays the role of an exemplary father, the child with a bent for medicine doubtless will turn naturally to the father's calling.

1. Medicine in the News 4:4 (Dec.) 1955.

National Cancer Conference Detroit, June 4-6, 1956

The Third National Cancer Conference will convene at the Sheraton Cadillac Hotel in Detroit on June 4 and continue through June 6. Co-sponsors

of the conference are the American Cancer Society and the National Cancer Institute. The meeting is an open one, and physicians from all parts of the country are cordially invited to attend. An interesting program is being planned by the local host committee for the wives of the physicians in attendance.

The elaborate scientific program consists of a series of symposiums on various cancers by site and constitutes a summarization of recent clinical developments in the diagnosis and treatment of cancer. The subjects covered are: breast, chemotherapy, female genital tract, gastrointestinal tract, head and neck, lung, lymphoma and leukemia, prostate, and end results. Several lectures are also scheduled.

The list of participants in the comprehensive program constitutes a roster of many of the most distinguished names in this country and abroad associated with cancer therapy and research. The Symposium on Cancer of the Breast is scheduled to continue through the morning and afternoon sessions on Monday, June 4, and to conclude with a joint symposium on cancer of the breast and of the prostate at the morning session on Tuesday. It will be opened by Dr. Ian Macdonald, University of Southern California School of Medicine, Los Angeles, who is chairman of the planning committee for this symposium. Among many others participating in this program are Dr. L. Henry Garland, Stanford University Medical School, San Francisco, and Dr. Cushman D. Haagensen, Columbia University College of Physicians and Surgeons, New York.

The Symposium on Lymphomas and Leukemias will continue through morning and afternoon sessions on Monday and will be concluded on Tuesday afternoon. Heading the planning committee and one of the speakers on this program is Dr. William Dameshek, New England Center Hospital, Boston. Among other nationally known participants are Dr. Lloyd F. Craver, Memorial Center for Cancer and Allied Diseases, New York, Dr. Alfred Gellhorn, Francis Delafield Hospital, New York, Dr. Sidney Farber, Children's Cancer Research Foundation, Boston, Dr. Maxwell M. Wintrobe, University of Utah College of Medicine, Salt Lake City, and Dr. Steven O. Schwartz, The Hektoen Institute for Medical Research of the Cook County Hospital, Chicago.

Among the distinguished participants presenting the Symposium on Cancer of the Prostate at both the morning and afternoon sessions on Monday are Dr. William W. Scott, Johns Hopkins University Medical School, Baltimore, Dr. Reed Nesbit, University of Michigan Medical School, Ann Arbor, Mich., and Dr. Arthur Purdy Stout, Columbia University College of Physicians and Surgeons, New York.

The Symposium on Cancer of the Gastrointestinal Tract continues through both sessions on Monday. Chairman of the planning committee for this presentation is Dr. George T. Pack, Memorial Center for Cancer and Allied Diseases, New York, and among other eminent physicians participating are Dr. Richard K. Gilchrist, Presbyterian Hospital, Chicago, Dr. Robert Zollinger, Ohio State University Medical School, Columbus, Ohio, Dr. John Waugh, Mayo Clinic, Rochester, Minn., and Dr. I. S. Ravdin, University Hospital, Philadelphia.

Featured at the morning and afternoon sessions on Tuesday will be the Symposium on Cancer of the Lung. Chairman of the planning committee for this program is Dr. Eugene P. Pendergrass, University of Pennsylvania School of Medicine, Philadelphia, and other members include Dr. John H. Gibbon, Jefferson Medical College, Philadelphia, and Dr. Richard H. Overholt, New England Deaconess Hospital, Boston.

Dr. Gellhorn will be among those participating in the Symposium on Chemotherapy in Cancer on Tuesday morning. The Symposium on Cancer of the Female Genital Tract will be presented at the morning and afternoon sessions on Tuesday. Among the participants are Dr. Joe V. Meigs, chairman of the planning committee, Vincent Memorial Hospital, Boston, Dr. George N. Papanicolaou, Cornell University Medical College, New York, and Dr. Arthur T. Hertig, Harvard Medical School, Boston.

Dr. Danely P. Slaughter heads the planning committee for the Symposium on Cancer of the Head and Neck, scheduled to continue through both sessions on Tuesday. Among the participants are Dr. James Barrett Brown, Washington University School of Medicine, St. Louis, and Dr. Hayes Martin, Memorial Center for Cancer and Allied Diseases, New York.

Both sessions on Wednesday will be devoted to the Symposium on End Results, which will include a series of reports from selected institutions on the current curability of cancer. Among those participating in the panel discussion on end results in the treatment of cancer by site will be Dr. Michael B. Shimkin, chairman of the planning committee, National Cancer Institute, Bethesda, Md., Dr. Overholt, Dr. Dameshek, Dr. Gellhorn, Dr. David

A. Wood, University of California School of Medicine, San Francisco, and Dr. Richard Sweet, Massachusetts General Hospital, Boston.

Physicians are urged to register well in advance of the meeting. The Conference precedes by one week the annual meeting of the American Medical Association in Chicago. Dr. Ashbel C. Williams, chairman of the Florida Cancer Council, announces that copies of the program, advance Conference registration cards and hotel reservation cards may be procured from the Florida Division of the American Cancer Society, 416 Tampa St., Tampa, the Florida State Board of Health, Jacksonville, or the Coordinator, Third National Cancer Conference, 521 West 57th St., New York 19, N. Y.

Graduate Medical Education

Short Course
June 25-29, 1956

The Twenty-Fourth Annual Graduate Short Course for doctors of medicine is scheduled for June 25-29 at the George Washington Hotel in Jacksonville. Sponsoring this annual event are the Division of Postgraduate Education of the College of Medicine of the University of Florida, the Florida State Board of Health and the Florida Medical Association. The subjects to be presented are Medicine, Pediatrics and Psychiatry on June 25, 26 and 27, and Surgery and Gynecology on June 28 and 29. The only night meeting will be on June 26 when the common diseases of the eye will be discussed.

Dr. James V. Warren, Professor of Medicine, Duke University School of Medicine, Durham, N. C., will lecture on Medicine. The lectures on Pediatrics will be presented by Dr. James G. Hughes, Professor of Pediatrics, University of Tennessee School of Medicine, Memphis, Tenn. The lecturer on Psychiatry will be Dr. Paul V. Lemkau, Director, Mental Health Service, New York Committee of Mental Health Board, New York.

The two lecturers presenting the subject of Gynecology will be Dr. Howard W. Jones Jr., Assistant Professor of Gynecology, The Johns Hopkins School of Medicine, Baltimore, and Dr. Georgeanna Jones, Staff Member, The Johns Hopkins Hospital, Baltimore. Dr. William R. Sandusky, Associate Professor of Surgery, School of Medicine, University of Virginia, Charlottesville, Va., will lecture on Surgery.

The schedule for the Short Course appears on the opposite page.

Seminar on Gastroenterology
June 21-23, 1956

The subject chosen this year for the special Seminar that customarily precedes the annual Short Course is Gastroenterology. The program planned should evoke wide interest and attract a large attendance. The course will continue for three days, beginning on Thursday, June 21, at 10 a.m. and concluding at noon on Saturday, June 23. As in the past, the Seminar will be held at the George Washington Hotel in Jacksonville.

The faculty members are Dr. David Cayer, Professor of Gastroenterology, The Bowman Gray School of Medicine, Wake Forest College, Winston-Salem, N. C., and Dr. E. Clinton Texter Jr., Associate Professor of Medicine and Director of the Gastroenterology Laboratory, Northwestern University Medical School, Chicago.

The schedule follows in detail:

THURSDAY, JUNE 21

9:00	Registration
10:00	Approach to Patient with Gastrointestinal Disorders, Dr. Texter
11:00	Recess
11:15	The Gastric Ulcer Problem, Dr. Texter
2:00	Pathophysiology of Peptic Ulcer, Dr. Texter
2:50	Recess
3:00	Peptic Ulcer—Newest Methods of Treatment, Dr. Texter
3:50	Recess
4:00	Hiatus Hernia, Peptic Esophagitis and Related Disorders, Dr. Texter

FRIDAY, JUNE 22

9:00	Needle Aspiration Liver Biopsy, Diagnostic and Therapeutic Aspects, Dr. Cayer
10:00	The Use of ACTH and Adrenal Steroids in Intestinal Disorders, Dr. Texter
11:00	Recess
11:30	Differential Diagnosis of Jaundice, Dr. Cayer
2:00	Cancer of the Pancreas, Dr. Cayer
3:00	Regional Enteritis and Enterocolitis, Dr. Texter
4:00	Recess
4:15	Acute Pancreatitis, Dr. Cayer

SATURDAY, JUNE 23

9:00	Hepatic Insufficiency, Dr. Cayer
10:00-12:00	Clinic and Question Period, Dr. Cayer, Dr. Texter

SCHEDULE FOR SHORT COURSE

HOUR	Monday June 25	Tuesday June 26	Wednesday June 27	Thursday June 28	Friday June 29
8:00	**Registration**				
9:00	**Medicine** "The Treatment of Congestive Heart Failure" Dr. Warren	**Medicine** "Fits and Faints" Dr. Warren	**Psychiatry** "Treatment of Psychiatric Illnesses and Its Effect on Mental Health Programs" Dr. Lemkau	**Surgery** "Peripheral Vascular Diseases: Part I" Dr. Sandusky	**Gynecology** "The Medical and Surgical Management of Repeated Abortion" Dr. G. Jones
10:00	**Pediatrics** "The Treatment of Purulent Meningitis in Infancy and Childhood" Dr. Hughes	**Pediatrics** "Jaundice in Early Infancy" Dr. Hughes	**Pediatrics** "The Treatment of Acute Nephritis in Children" Dr. Hughes	**Gynecology** "Management of Functional Uterine Bleeding" Dr. Jones	**Surgery** "Gastrointestinal Bleeding: Part I" Dr. Sandusky
11:00	**Recess**	**Recess**	**Recess**	**Recess**	**Recess**
11:30	**Psychiatry** "The Size and Range of Problems in Mental Health" Dr. Lemkau	**Psychiatry** "Opportunities for the Prevention of Mental Illnesses of Psychologic Origin" Dr. Lemkau	**Medicine** "The Lungs and the Circulation in Circulatory Diseases" Dr. Warren	**Surgery** "Peripheral Vascular Diseases: Part II" Dr. Sandusky	**Gynecology** "The Management of Ovarian Tumors" Dr. Jones
12:30	**Lunch**	**Lunch**	**Lunch**	**Lunch**	**Lunch**
2:00	**Pediatrics** "The Treatment of Severe Diarrhea in Infancy" Dr. Hughes	**Medicine** "Iatrogenic Disease" Dr. Warren	**Pediatrics** "A Practical Approach to Behavior Problems in Children" Dr. Hughes	**Gynecology** "The Significance of Management of Intraepithelial Carcinoma of the Cervix" Dr. Jones	**Surgery** "Gastrointestinal Bleeding: Part II" Dr. Sandusky
3:00	**Recess**	**Recess**	**Recess**	**Recess**	**Recess**
3:15	**Psychiatry** "Opportunities for Preventive Efforts Through Protection of the Central Nervous System" Dr. Lemkau	**Medical Panel** Subject to be announced Panel Members: Dr. Warren Dr. Hughes Dr. Lemkau	**Medicine** "The Recognition and Management of Pericardial Disease" Dr. Warren	**Surgery** "Antibacterial Agents in Surgery" Dr. Sandusky	**Surgical Panel:** **Question Period on Surgery and Gynecology** Panel Members: Dr. Sandusky Dr. Jones Dr. G. Jones
4:15	**Recess**		**Recess**	**Recess**	
4:30	**Medicine** "Changing Concepts of Coronary Artery Disease" Dr. Warren		**Psychiatry** "The Design of Programs for the Promotion of Mental Health and the Prevention of Mental Diseases" Dr. Lemkau	**Gynecology** "The Management of Hermaphroditism and Allied Conditions" Dr. Jones	
8:00		Evening Meeting on Commoner Disorders of the Eye			

Unsnarling the Traffic Accident Problem Miami Beach Regional Conference May 14-15

The national regional conference on traffic safety, to be held in Miami Beach on May 14 and 15, is of particular interest to physicians now that they are taking an active role in reducing the number of traffic accidents. It also would interest the late Thomas A. Edison, so long a Floridian by adoption. It was he who said that one of the biggest benefits of the automobile was to make the American people dissatisfied. In his opinion, the coming of the automobile stirred up the spirit of initiative and independence that typified the pioneers who fought and settled this country. With the coming of the twentieth century, the last physical frontier was gone, and the nation was almost standing still, about to lose that spirit. Then the automobile arrived to end the ennui. Travel brought awareness of the full scope of the national potentialities for a still better way of life. There was now the challenge of endless new frontiers — of economic progress, health, education, better living, and countless other goals to be attained.

After half a century of astounding progress in the wake of the automobile, Mr. Edison, along with every citizen of the United States today, could well inquire if this blessing is to be allowed to boomerang into a menace to life and limb, killing and maiming out of all reason. If ever the automobile was destined to make the nation dissatisfied, it is operating now to make for universal dissatisfaction with the traffic toll. Confronting the citizenry today is a new frontier of traffic safety — a goal earnestly to be sought by all in the interest of self preservation.

Some 92,000 persons were fatally injured in the United States during 1955. This figure represents a rise in accident fatalities which "reflects very largely the increase in mortality from motor vehicle accidents. Deaths from such accidents climbed to about 38,500 in 1955, about 2,500 more than the year before and the highest number in fourteen years."[1] Add to this number 1,350,000 injured and an economic loss of nearly five billion dollars.

These appalling figures stress the timeliness of the Committee For Traffic Safety, appointed by President Eisenhower and headed by Harlow H. Curtice of General Motors. In a recent letter to President Elmer Hess of the American Medical Association, Rear Admiral H. B. Miller, who directs the President's Committee, requested the names of two officers of each state medical society. They are being invited to attend regional conferences across the nation this month — in Miami Beach, Atlantic City, Chicago and San Francisco. The names of the officers of all of the state societies were furnished the committee.

At the southern regional conference in Miami Beach the American Medical Association will be represented by Dr. Fletcher D. Woodward, of Charlottesville, Va., chairman of the A.M.A. Committee on Medical Aspects of Automobile Injuries. This meeting will be in session at the same time the Florida Medical Association is holding its annual convention in that city.

These regional meetings of the President's Committee are an extension of the 1954 White House Conference on Highway Safety. Their purpose is to promote a renewed, stepped-up effort to develop organized citizen groups in every state and community to support full application of proved traffic-safety technics. Certainly this effort deserves full support. The number of injuries and fatalities resulting from the operation of motor vehicles undoubtedly could be reduced materially, but this goal will be attained only through cooperation of the citizenry, particularly the intelligent cooperation of pedestrians, automobile operators and law enforcement agencies.

1. Statistical Bulletin, Metropolitan Life Insurance Company, December 1955, p. 5.

Florida Mental Health Council Makes First Report

The first semiannual report of the Council on Training and Research in Mental Health is now available. It has been prepared, Chairman Robert W. Kleemeier announced, for the information of the many individuals and organizations aware of the problems of mental illness and mental health and interested in the development of a training and research program.

The Council was created by an Act of the 1955 Florida legislature which provided for appointment by the Governor of six professional and five lay members, and for an appropriation of $250,000 for the biennium to carry out the purposes of the bill. It is charged by law with the responsibility of advising and recommending to the Florida State Board of Health: (a) The administration of all funds appropriated by this Act; (b) The awarding of training grants for psychiatric social work, psychiatry, clinical psychology and psychiatric nursing; and (c) Making of

allotment for mental health research projects. The legislation creating the Council was part of a well considered plan to meet, in some degree, recognized needs and to improve the expression of the state's responsibility for curing mental illness and improving mental health.

Addressing the appointees on the occasion of the formal organization of the Council, Governor Collins declared himself devoted to the concept of Disraeli, who once said: "The health of the people is really the foundation upon which all their happiness and all their powers as a State depend." Not only in Florida, the Governor pointed out, but all over the land, there is a crying shortage of trained personnel competent to deal with the problem of mental health. "And when we realize," he continued, "that there are more people in America suffering from mental illness than all other illnesses combined, we will have come face to face with the biggest single health problem facing our State and Nation. Our State must do so much more than it is now doing to meet its responsibilities in this vital field. Because our people have only recently begun to recognize and express interest in this important problem and because medical science has just begun to probe the darkness in this area, there lies ahead a monumental task. . . . But we must make a beginning—and we have done so."

In this initial report the Council reports a great deal of progress in carrying forward the program to meet the needs for more and better trained mental health personnel in Florida. It outlines the progress and sets forth the problems in a constructive approach to the solution of the many challenges confronting it in its task of creating a program of training and research adequate to the need. Copies of the report may be obtained by addressing the Council at P.O. Box 210, Jacksonville.

1955 Medical Education Contributions

The American Medical Education Foundation recently announced the 1955 state totals of physician contributions to medical education. The medical schools and the directors of their alumni associations cooperated remarkably well to give a much more accurate breakdown of contributors by state than in previous years. There is, therefore, a miscellaneous entry of $3,454 in the 1955 figures compared to $712,742 as a miscellaneous figure in 1954. In addition, the figures for this year have been more carefully edited to exclude all donations such as scholarships and research grants which could not be interpreted as unrestricted gifts. When a donation would clearly become a part of the operating budget, however, it was included. A plan is currently being worked out to tabulate and report this type of alumni gift in 1956.

Florida physicians who contributed through the Foundation in 1955 numbered 57, and there were 640 who made contributions direct to medical schools, a total of 697 contributors. The former contributed $4,799 and the latter $19,558, making the entire amount $24,357. The complete totals for the nation were 25,116 contributing $757,163 to the Foundation, and 31,944 giving $1,748,587 direct to the medical schools, a total of $2,505,750.

A directory is now in preparation which will contain the names of all who have given to the Foundation or direct to the medical schools. It will be distributed soon.

New York County Medical Society Sesquicentennial

New York City appears to hold the honor of adopting the first effectual measures for regulating the practice of medicine in the United States. On June 10, 1760, an act to regulate the practice of Physic and Surgery in that city, later known as the colonial law, quaintly but articulately phrased, began:

> Whereas, many ignorant and unskilful Persons in Physick and Surgery in order to gain a subsistence, do take upon themselves to administer Physick, and practice Surgery in the City of New York, to the endangering of the Lives and Limbs of their Patients; and many poor and ignorant Persons inhabiting the said City, who have been persuaded to become their Patients, have been great sufferers, thereby: For preventing such Abuses for the Future:
>
> I. BE IT ENACTED . . . That, from and after the publication of this Act, no Person whatsoever shall practice as a Physician or Surgeon . . . before he shall first have been examined . . . and approved of and admitted by one of his Majesty's Council, the Judges of the Supreme Court, the King's Attorney-General, and the Mayor of the City of New-York . . . taking to their assistance for such examination, such proper Person or Persons as they in their discretion shall see fit. . . .
>
> II. AND BE IT FURTHER ENACTED . . . That if any Person shall practice . . . without such testimonial . . . he shall for every such offence forfeit the sum of Five Pounds; one-half thereof to the use of the Person or Persons who shall sue for the same, and the other Moiety to the Church Wardens and Vestrymen . . . for the use of the Poor. . . .

After repeated attempts were made to regulate the practice of medicine on a statewide basis in New York, an official act of the state legislature was obtained on April 4, 1806. As a result, many

(Continued on page 946)


TRANS WORLD AIRLINES
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ACHROMYCIN*

Tetracycline *Lederle*

in the treatment of

respiratory infections

January and his associates[1] have written on the use of tetracycline (ACHROMYCIN) to treat 118 patients having various infections, most of them respiratory, including acute pharyngitis and tonsillitis, otitis media, sinusitis, acute and chronic bronchitis, asthmatic bronchitis, bronchiectasis, bronchial pneumonia, and lobar pneumonia. Response was judged good or satisfactory in more than 84% of the total cases.

Each month there are more and more reports like this in the literature, documenting the great worth and versatility of ACHROMYCIN. This antibiotic is unsurpassed in range of effectiveness. It provides rapid penetration, prompt control. Side effects, if any, are usually negligible.

No matter what your field or specialty, ACHROMYCIN can be of service to you. For your convenience and the patient's comfort, Lederle offers a *full* line of dosage forms, including

ACHROMYCIN SF

ACHROMYCIN with STRESS FORMULA VITAMINS. Attacks the infection—defends the patient—hastens normal recovery. For severe or prolonged illness. Stress formula as suggested by the National Research Council. Offered in Capsules of 250 mg. and in an Oral Suspension, 125 mg. per 5 cc. teaspoonful.



For more rapid and complete absorption. Offered only by Lederle ! **dry-filled sealed capsules**

[1]January, H. L. et al: Clinical experience with tetracycline. *Antibiotics Annual* 1954-55, p. 625.

Lederle

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*REG. U. S. PAT. OFF.

PHOTO DATA: 4X5 VIEW CAMERA, F5.6, 1/25 SEC., EXISTING LIGHTING AT DUSK, ROYAL PAN FILM.

(Continued from page 943)

local societies were organized. The Medical Society of the County of New York, said to be the oldest medical organization in the state, was founded when 102 physicians assembled on the steps of City Hall and publicly proclaimed the society of physicians to exist. On July 1, 1806, the society was incorporated. Since that time this outstanding society with its ups and downs, struggles and problems, successes and final achievements has served as a pioneer medical organization on which other local societies might set their sites to help guide them through their own vicissitudes and struggles.

Always a strong organization, the Medical Society of the County of New York with some 2,500 members 40 years ago and some 7,000 today is not only one of the most influential, but the largest county medical society in the nation. During the month of April 1956 it celebrated its Sesquicentennial, re-enacted the scenes of its founding 150 years ago and rededicated itself to the service of the citizens of New York. The Florida Medical Association and its component county medical societies take pride and pleasure in offering felicitations and salutations to their distinguished sister in the North.

Popular Fair Exhibit

The recently completed A.M.A. exhibit "Life Begins," designed to present to the public a basic concept of the anatomy associated with conception and birth, was displayed at the Florida State Fair in Tampa early in February. It was sponsored by the Florida Medical Association. The exhibit features human fetuses in nine stages of development from four and one-half weeks to nine months, all imbedded in plastic. In addition, it depicts methods of fertilization and six stages of birth.

Officials estimated that more persons saw this exhibit than any other in the growing State Fair, whose gate attendance tops one million. Over 10,000 pieces of medical literature, all stamped with the Association's name, were handed out by members of the staff of the Bureau of Public Relations, who were in continuous attendance throughout the Fair. "Life Begins," occupying a 30 foot space in the Florida Building, drew many persons into the building with the sole idea of seeing the one exhibit, which was constantly crowded with onlookers.

Following the Tampa showing, the exhibit was moved to Orlando, where it was displayed with equal success at the Central Florida Fair, February 20-25, sponsored by the Orange County Medical Society. Free blood pressure readings were offered as an added attraction at the Orlando showing, and some 5,000 persons took advantage of this unusual opportunity to learn their blood pressure. The readings were taken by student nurses from Orange Memorial Hospital and Florida Sanitarium and Hospital, assisted and supervised by members of the Woman's Auxiliary to the Orange County Medical Society.

A third successful showing was staged during the month of March in Miami, where the exhibit was displayed at the student union lounge of the University of Miami, sponsored by the Dade County Medical Association. Many physicians in the Dade County area recommended "Life Begins" to their obstetric patients for its valuable additional information. Dr. Christian Keedy, chairman of the Committee on Public Relations



Fig. 1.—Crowds throng the popular fair exhibit "Life Begins" at the Florida State Fair in Tampa (left) and at the Central Florida Fair in Orlando (right), where blood pressure reading was an added feature. Following these two February showings, the exhibit was moved to Miami and shown with equal success at the University of Miami during March.

of the Dade County Medical Association, was in charge of the showing.

In charge of arrangements for the Tampa showing was Dr. Eugene B. Maxwell of Tampa, a member of the Association's Public Relations Advisory Committee. The showing at Orlando was directed by Dr. Robert E. Zellner, chairman of the Committee on Public Relations of the Orange County Medical Society.

CLASSIFIED

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

FOR SALE: Retirement necessitates finding seasoned general practitioner to take over active long established practice with minimum income of $20,000 per year. Located in South Central Florida Ridge District. Fully equipped, exceptional laboratory and good hospital facilities available. Immediate occupancy. Will introduce. Price and terms nominal to right party. Write 69-181, P.O. Box 1018, Jacksonville, Fla.

FOR SALE: Established office and living quarters. Completely equipped for immediate practice. $50,000 to $65,000 gross. Two reception rooms, three examining rooms. Laboratory, X-Ray room, photo dark room. Air conditioned and sound insulated. Easy terms. Write George W. Lubke, Inc., 601 N. Atlantic, Daytona Beach, Fla.

SPECIALIST GROUP FORMING: Large common waiting room. Reception office. Intercom, air-contioned, heat. Very reasonable. Paved parking lot. Also two separate office suites for general practice, each with private waiting room. Medical Dental Arts Bldgs., 1000 S. Federal Highway, Fort Lauderdale. Phone JA 4-3671.

WANTED: Physician retiring, would like physician to take office. Ideal location for obstetrician. Ten miles from hospital. Write William C. Williams Jr., M.D., P.O. Box 347, Delray Beach, Fla.

RADIOLOGIST: Board certified in diagnosis and therapy, wishes to establish himself in growing Florida community. Private and/or hospital opportunity considered. Florida license. Write 69-182, P.O. Box 1018, Jacksonville, Fla.

PEDIATRICIAN: Desires association with another Pediatrician or group. Board eligible, married, age 30. Military service completed. Florida license. Available July 1956. Write 69-183, P.O. Box 1018, Jacksonville, Fla.

GENERAL PRACTITIONER: Wanted for inland town of South Florida with about 5,000 population. Hospital facilities available. Write 69-184, P.O. Box 1018, Jacksonville, Fla.

RADIOLOGIST: Board certified with Florida License. Seeks Southeast Florida location. Isotope training. Currently University Medical School affiliated. Age 32, experienced. Write Box 152 G. P. O., New York 1, N. Y.

INTERNIST: Completes training July 1, 1956. Desires association with another internist or group. Age 29, Class IV Draft. Write 69-185, P. O. Box 1018, Jacksonville, Fla.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Aulls, Ernest C., Grand Island
Carter, William D., Panama City
Donovan, Stephen J., Hollywood
Eaton, Joseph W., St. Petersburg
Edmiston, John M., Plant City
Faykus, Max H., Tampa
Funt, Tobias R., Fort Lauderdale
Halden, Harry E. III, Lakeland
Hall, Charles C., Orlando
Haugen, Roger K., Fort Lauderdale
Hornsby, Aubrey T., Orlando
Jelstrom, Harry C., Fort Lauderdale
Kneedler, Milo W., Eustis
Larkum, Newton W., Fort Myers
Peacock, Avon J. Jr., Plant City
Silsby, Harry Z., Sanford
Sotolongo, Hugo F., Live Oak
Stratton, Albert F. Jr., Cocoa
Wharton, Dwight J., Tampa
Williams, John I., Fort Lauderdale
Williams, Walter S., Fort Lauderdale

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Ray O. Edwards Jr., of Jacksonville, announce the birth of a son, William Thomas, on January 28, 1956.

Dr. and Mrs. Andrew J. Leon, of Miami Beach, announce the birth of a daughter, Denise Ann, on January 8, 1956.

Dr. and Mrs. Apostolos A. Kartsonis, of Jacksonville, announce the birth of a son, Athan Paul, on January 8, 1956.

Dr. and Mrs. Edward W. St. Mary, of Miami, announce the birth of a son, Karl Robert, on February 1, 1956.

Dr. and Mrs. Hugh B. Haston Jr., of Jacksonville, announce the birth of a daughter, Holly Melinda, on January 18, 1956.

Dr. and Mrs. David R. Moomaw, of Jacksonville, announce the birth of a daughter, Audrey Jean, on February 10, 1956.

Dr. and Mrs. Joseph T. Jana Jr., of Miami, announce the birth of a daughter, Barbara Ann, on February 2, 1956.

Dr. and Mrs. Leon H. Mims Jr., of Miami, announce the birth of a son, Leon Heberden III, on March 3, 1956.

Marriages

Dr. Henry W. Shupe, of Clewiston, and Miss Barbara Figley were married March 10, 1956, in Clewiston.

Deaths — Other Doctors

Patterson, Willard A. (Col.), Brunswick, Ga., November 20, 1955.

STATE NEWS ITEMS

The Eighth Annual Meeting of the Southern Neurosurgical Society was held at Jacksonville, March 23-24, with headquarters in the George Washington Hotel.

Speakers on the program for the opening day of the meeting included Drs. Edward J. Sullivan Jr., James G. Lyerly, William H. McCullagh and William Ingram Jr., of Jacksonville, and Drs. Richard E. Strain and Irwin Perlmutter, of Miami.

"Prefrontal Lobotomy and Occlusion of the Anterior Choroidal Artery for Parkinson's Disease" was the title of the paper by Drs. Sullivan and Lyerly. Drs. McCullagh and Ingram discussed "Electroencephalography in the Diagnosis of Neurological Diseases" and Drs. Strain and Perlmutter presented a discussion of "Prefrontal Lobotomy for Intractable Pain." Dr. Lyerly was host for the meeting.

Officers of the Society elected at a business meeting held at noon, March 24, were Dr. Dale Crutchfield, president, Charlottesville, Va., Dr. C. D. Hawkes, secretary-treasurer, Memphis, Tenn., and Dr. William Meacham, vice president, Nashville, Tenn.

Dr. A. MacKenzie Manson of Jacksonville has been elected president of the Legal Aid Association of that city.

Dr. Manuel G. Carmona of Hollywood discussed cancer at a recent meeting of the Licensed Practical Nurses Association, Chapter 17A, held in the Broward County Health Building at Hollywood.

Dr. Thomas E. Morgan, Duval County health officer, has been elected chairman of the Florida Health Officers Conference. Dr. Henry I. Langston of Marianna, health officer for Jackson and Calhoun counties, has been named secretary.

The 1956 Fall Meeting of the Florida Academy of General Practice has been scheduled for October 20-21 in the Roosevelt Hotel, Jacksonville, according to announcement by Dr. Leo M. Wachtel Jr. of Jacksonville, president-elect of the Academy.

Dr. Marvin B. Miller of Tampa was featured speaker at a meeting sponsored by the Hillsborough County Nutrition Committee at Tampa recently for women interested in nutrition and food. Dr. Miller discussed the advantages of weight control.

"The Scarlet Cord," a new novel by Dr. Frank G. Slaughter of Jacksonville, has been published by Doubleday and Co., Garden City, N. Y. A Biblical novel, the book tells the story of Rahab and the historic battles in which Joshua is the central figure.

Dr. John E. Maines Jr. of Gainesville has returned from New Orleans where he attended a postgraduate medical assembly at the Tulane University School of Medicine.

Dr. George H. McSwain of Daytona Beach was principal speaker at a recent meeting of the Woman's Club of that city. The title of his address was "Quackery in Cancer."

Dr. Roderick C. Webb of Panama City discussed "Medical Public Relations" at a mid-March meeting of doctors' assistants from Bay, Franklin and Gulf counties. The meeting was held at Panama City.

The TRAINING SCHOOL at VINELAND, NEW JERSEY

For Retarded and Slow-Learning Children Established in 1888 as the "Village of Happiness"; for boys and girls, all ages. Academic, vocational, social training; wide recreation; cottage living; medical, psychiatric, psychologic services. Year-round program. Special Summer Program. Internationally known research center.

Write Director, The TRAINING SCHOOL at VINELAND, NEW JERSEY. Phone 7-0021

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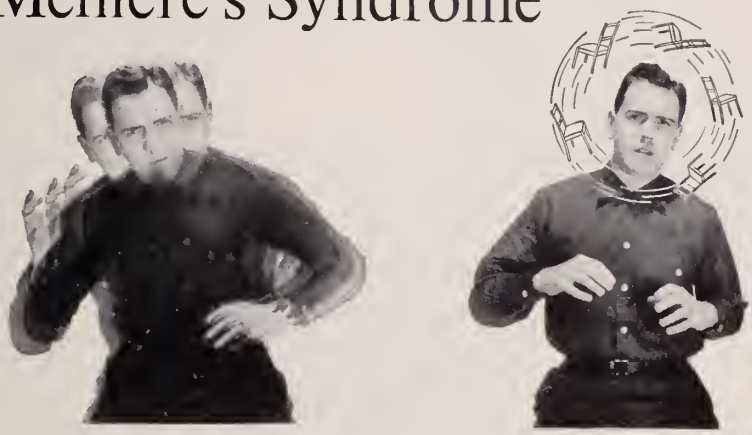
HAROLD SWANBERG, B.S., M.D., Director

W. C. U. Bldg. Quincy, Illinois

DRAMAMINE® IN VERTIGO

Notes on the Diagnosis and Management of "Dizziness"

III. Ménière's Syndrome



1. Paroxysmal Whirling Vertigo. *This consists of sudden attacks of dizziness, often when the patient is at rest or asleep. The patient may feel that he himself is whirling or that fixed objects about him are whirling. The attack usually lasts for a few minutes; occasionally it is severe for weeks or subacute for months.*



2. Subtotal Hearing Loss. *Deafness will usually affect the high tones and it may be unilateral or bilateral. Sometimes the hearing loss is severe and also progressive.*

3. Tinnitus. *This is usually unilateral and present in the ear with greater hearing loss and is without a definite pattern.*



Fewer diagnostic errors[1] will result if a "triad of symptoms" is required of patients with suspected Ménière's syndrome. These are the symptoms of typical Ménière's syndrome:

1. Severe paroxysmal vertigo which may be of two types; either the patient feels that he is whirling or that objects about him are whirling.
2. Fluctuating subtotal hearing loss, usually affecting the higher tones, is noted at the same time as vertigo.
3. Tinnitus, usually unilateral, is associated with the deafness and dizziness.

With Ménière's syndrome there is no definite localization[2] by the Bárány (vestibular reaction) test and results of the caloric test are not diagnostic. Physical examination should rule out disease of the central nervous or cardiovascular systems before a diagnosis is made.

"Treatment with Dramamine®. . . is effective[3] in aborting and preventing attacks of Ménière's syndrome . . . will prevent or arrest attacks of vertigo. It will also reduce the intensity of the tinnitus and so may save some of the hearing in the affected ear."

Dramamine is recommended for Ménière's syndrome as the sole therapy or in combination with other treatment programs.

It is a therapeutic standard also for motion sickness and is useful for relief of nausea and vomiting of radiation sickness and fenestration procedures.

Dramamine (brand of dimenhydrinate) is supplied in tablets (50 mg.); Supposicones® (100 mg.); ampuls (250 mg.); liquid (12.5 mg. in each 4 cc.). G. D. Searle & Co., Research in the Service of Medicine.

1. DeWeese, D. D.: Symposium: Medical Management of Dizziness. The Importance of Accurate Diagnosis, Tr. Am. Acad. Ophth. *58*:694 (Sept.-Oct.) 1954.
2. Jackson, C., and Jackson, C. L. (editors): Diseases of the Nose, Throat, and Ear, Philadelphia, W. B. Saunders Company, 1945, pp. 368; 414.
3. Queries and Minor Notes: Ménière's Syndrome, J.A.M.A., *141*:500 (Oct. 15) 1949.

A new edition of "Dramamine Reviews and Abstracts," containing digests of more than 100 recent articles, is available on request to . . . SEARLE P. O. Box 5110, B Chicago 80, Illinois

Ataractics and Holotherapy in

MENTAL and EMOTIONAL DISORDERS

Already clearly historical are the major successes due to use of the new ataractics, or tranquilizers, in mental and emotional disorders. Still vital, however, to enduring, optimal remission in *all* such disorders is the assurance of *adequate* nutrition — a therapeutic and prophylactic *fundamental.* For, the nervous system, even with the aid of the most efficacious drug, simply cannot function normally unless adequately supplied with essential nutrient factors.

Optimal treatment of all mental and emotional disorders whether mild or severe, acute or chronic, assures intake of optimally balanced, complete protein, vitamins and minerals — routinely, in adequate supply.

Patients with even the mildest of neuroses are under psychic stress. And stress increases the requirements for vitamins of the B complex. Deficiency of these vitamins or of essential amino acids instigates a tendency toward psychopathologic symptoms. A vicious cycle may thus be produced — to respond optimally only to total treatment, or *holotherapy,* which takes into account the *fundamental:* adequacy and balance of nutrients.

"Brewers' yeast is an excellent source of proteins of high biologic value and of the vitamins of the B complex.... When it is desired to give additional vitamins of the B complex and to add to the protein quota of the diet, this food can profitably be incorporated in other foods."*

VITA-FOOD Brewers' Yeast

an eminently valuable natural supplement — with these unique advantages:

- **Richest natural source of vitamin B complex factors plus nutritionally complete protein**
- **Optimal balance of amino acids and B complex factors**
- **Important source of minerals**

VITAMIN FOOD CO., INC. Newark 4, N. J.

*McLester, J. S., and Darby, W. J.: Nutrition and Diet in Health and Disease, ed. 6, Phila., Saunders, 1952, p. 195.

Dr. George W. Karelas of Newberry and Dr. Walter E. Murphree of Gainesville have returned from Washington, D. C., where they attended the 1956 Scientific Assembly of the American Academy of General Practice.

Dr. Rothwell C. Polk of Jacksonville spoke on "Cancer" to three different church groups in the city during March following the showing of a film on cancer by the American Cancer Society.

Drs. Jack H. Bowen, George M. Stubbs and Marvin H. Johnston of Jacksonville presented a cancer control program early in March in the Knights of Phythias Hall of that city. The physicians explained the cancer control program as it operates in Duval County.

Dr. Stanley Frehling of Miami Beach has been appointed chairman of the Brandeis University Club of Greater Miami.

Dr. Wm. E. Van Landingham of West Palm Beach was principal speaker at a March meeting of the Community Services Council of West Palm Beach.

Dr. W. Ansell Derrick of Orlando discussed cancer at a recent meeting of the Orlando Realty Board. He explained to Board members that frequent examinations for cancer were the best means of dealing with the nation's second worst killer.

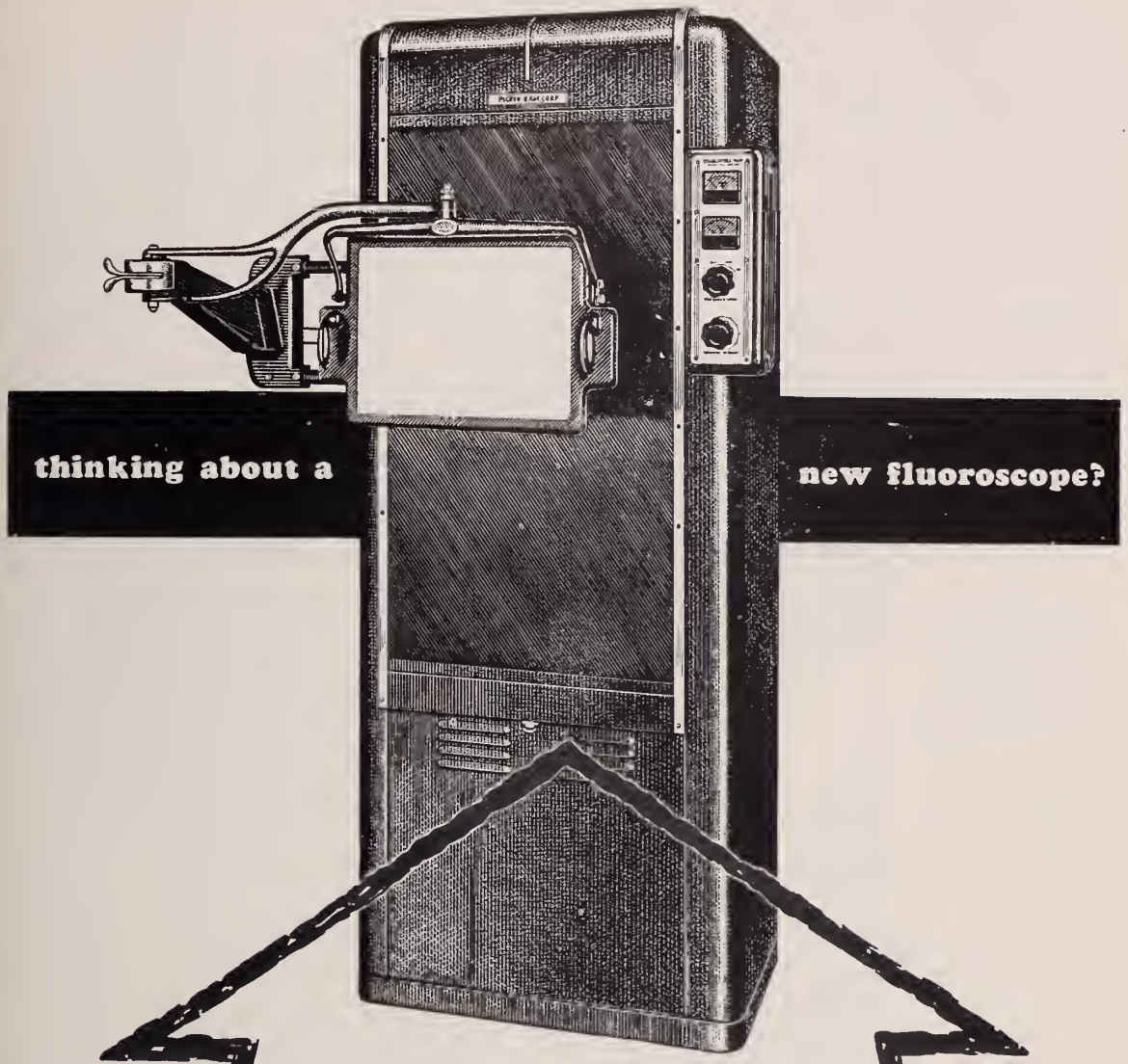
Dr. Arthur C. Tedford of Melbourne was guest speaker for a mid-March meeting of the Rotary Club there.

Dr. William Ingram Jr. of Jacksonville was principal speaker at the March meeting of the Orange Street School P-TA of St. Augustine. Dr. Ingram outlined the purpose and functions of a Child Guidance Clinic.

Dr. James H. Miller of Dunedin was guest speaker at a recent meeting of the Rotary Club of Clearwater. Dr. Miller discussed the history of medicine and advances made in recent years as applied in the struggle to control cancer.

Dr. Jack W. Fleming of Pensacola addressed a recent meeting of the Pensacola Lions Club.

(Continued on page 954)



thinking about a new fluoroscope?

get a fine one... the little more it may cost* will pay off handsomely in the long run. A fine Picker fluoroscope like this will serve you efficiently for many a long year. It is built by the same skilled craftsmen to the same high standards as the Picker apparatus used in three out of four Medical Schools and Teaching Institutions in the U. S. and Canada.

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Picker x-ray apparatus is backed by a service organization without peer in the field. There's a local Picker office near you, ready to serve you well and promptly in anything having to do with x-ray.

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The above advertisements appeared recently in Life, Saturday Evening Post, and Today's Health.

"How to look at a doctor's bill" could well serve as the title for recent Parke-Davis advertisements on the cost of medical care. For they suggest to the public new ways of looking at the extraordinary *value* one buys with each dollar spent for prompt and proper medical care.

These Parke-Davis messages talk in everyday language about familiar but "forgotten" facts. Some examples: the steadily decreasing cost of curing diseases such as pneumonia, the phenomenal reduction in the death-rate for children, the substantial savings in time and income because of the shortened duration of hospital stays.

By highlighting the heartening facts of medical progress in relation to the cost of medical care, this new series hopes to help in creating a healthy, realistic public opinion on the reasonableness of medical costs.

To do this successfully, we wish the facts to have the widest possible readership. Therefore these advertisements are being published regularly in such mass-circulation magazines as LIFE, the SATURDAY EVENING POST, and TODAY'S HEALTH.

If you would like to have folder-size reprints of any of these ads for your reception room, we will be happy to supply them on request.





PARKE, DAVIS & COMPANY

Detroit 32, Michigan

(Continued from page 950)

Dr. Edward R. Annis of Miami was guest speaker for the breakfast meeting held early in March for alumni in the greater Miami area of Jesuit colleges and universities.

Dr. Bernard F. O'Hara of West Palm Beach was principal speaker at a recent meeting of the St. Juliana's Home School Association held in the city. Dr. O'Hara outlined the more common communicable diseases in children and gave a comprehensive report on immunizations to prevent the diseases.

Dr. Lowrie W. Blake of Bradenton discussed "Cancer; Benign and Malignant Tumors" at a recent meeting of Licensed Practical Nurses of Manatee County held in the County Health Department Building there.

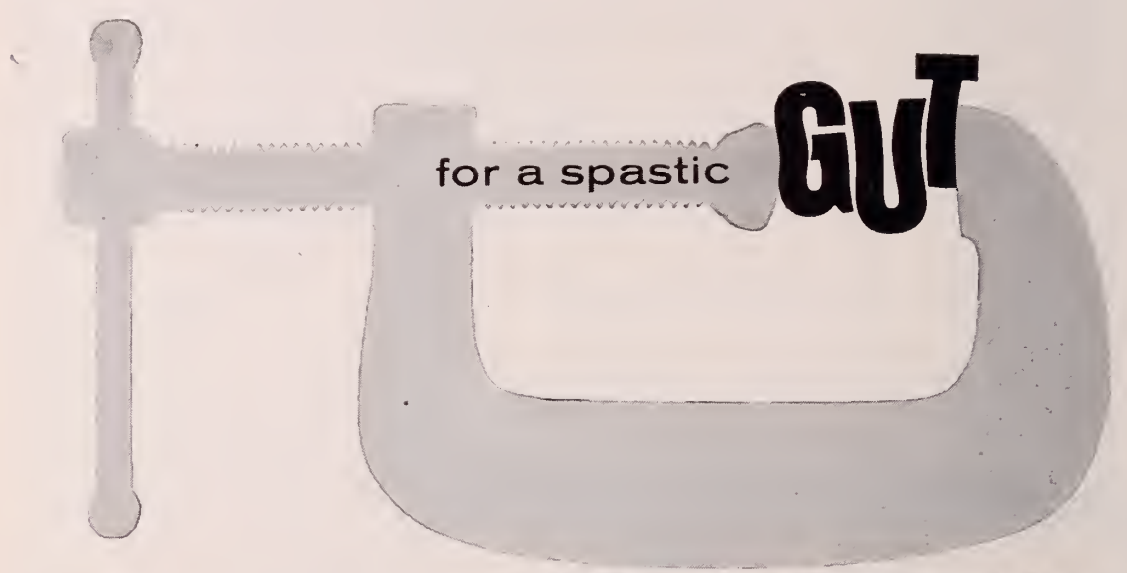
Dr. Herbert A. King of Daytona Beach discussed heart diseases and internal medicine at an early March meeting of Licensed Practical Nurses of that city.

Dr. Daniel O. Hammond of Miami presented a case report on "Unusual Manifestations of Endometriosis" at a March meeting of the Miami Obstetrical and Gynecological Society.

Dr. C. Ashley Bird of Jacksonville presented a paper on "Neurosurgical Problems Commonly Seen in General Practice" and also presented a motion picture on "Surgical Treatment of Involuntary Muscular Disorders" before the South Georgia Medical Society meeting in Valdosta the middle of March.

The Second Postgraduate Course in Esophageal Speech and Organic Voice Problems sponsored by the University of Miami School of Medicine has been scheduled for June 18-30. The Course is under the direction of Dr. Nathaniel M. Levin of Miami and his staff. Physicians interested in the course should contact Dr. Homer F. Marsh, Dean, University of Miami School of Medicine, Coral Gables.

Dr. Charles F. Crampton, assistant professor of pathology in the University of Florida's College of Medicine, Gainesville, has been awarded a Markle Scholarship. He becomes the fourth member of the faculty to hold this honor.



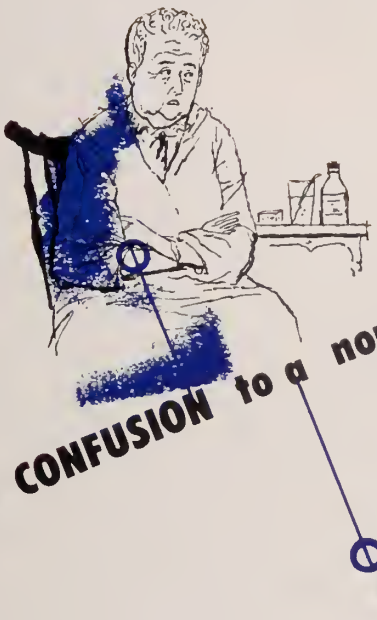
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1. *Levy, S.* J.A.M.A. *153:1260, 1953.*
2. *Thompson, Lloyd & Proctor, Rich.* N. C. State, *Dec. 54*
3. *Thompson & Proctor,* Clinical Med. *April, 1956*

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Dr. Anthony D. Migliore of Arcadia discussed "Admission, Treatment and Discharge of the Psychotic Patient" at a March meeting of the Woman's Club of Arcadia. Questions by the audience showed an interest in the new tranquilizing drugs.

Dr. Madison R. Pope of Plant City has been appointed a member of the State Board of Medical Examiners to succeed the late Dr. Charles W. Bartlett.

Dr. Emanuel Suter has been appointed head of the Department of Microbiology of the College of Medicine, University of Florida. Dr. Suter presently is in the Department of Bacteriology and Immunology at The Harvard Medical School. His new appointment becomes effective in June.

The Fifth Annual Symposium for General Practitioners on tuberculosis and other chronic pulmonary disease is scheduled for Saranac Lake, N. Y., July 9-13. It is approved for 26 hours of formal credit for members of the American Academy of General Practice. Information on the Symposium may be obtained from Dr. Edward N. Packard, P. O. Box 262, Saranac Lake, N. Y.

Dr. J. Ellis Lanier has been elected president of the Duval County Academy of General Practice. Serving with Dr. Lanier will be Dr. Samuel J. Alford, vice president; Dr. Charles H. Burke, secretary, and Dr. Ben T. Franklin Sr., treasurer. Chosen directors were Drs. Charles F. Henley, Elmer E. Leitner and Sidney Halpern.

Dr. Ashbel C. Williams of Jacksonville has been appointed a member of the Cancer Committee of the American College of Surgeons.

Dr. William Stromberg of Jacksonville entered medical service with the U. S. Coast Guard on July 8, 1955, with the rank of captain.

Dr. Richard E. Perry of Gainesville entered medical service with the U. S. Army on April 3, 1955, with the rank of first lieutenant.

Dr. John N. Sims Sr. of Like Oak entered medical service with the U. S. Army on February 27, 1956, with the rank of captain.

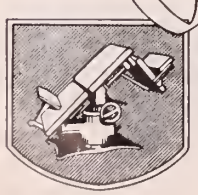
Drs. Frederick H. Bowen and F. Gordon King of Jacksonville attended the Twenty-Fourth Annual Assembly of the Southeastern Surgical Con-

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gress held recently at Richmond, Va. Dr. Bowen presented a paper on "Obstruction of the Small Bowell Due to Boli of Ingested Coconut Meat."

Dr. Hugh A. Carithers of Jacksonville discussed "Recent Advantages in Viral Diseases" as guest speaker at the March meeting of the Glynn County Medical Society held at Brunswick, Ga.

Dr. David Sloane of Lakeland was principal speaker for the meeting of Doctors' Office Assistants of Western Polk County sponsored by Blue Shield of Florida on April 3 at the Lakeland Yacht and Country Club. The subject of Dr. Sloane's address was "The Public Relations Program of our State and County Medical Societies."

Medical Officers Returned

Dr. M. Eugene Flipse, who entered military service on February 15, 1954, was released from active duty on February 15, 1956 with the rank of commander, U. S. Navy. His address is Department of Medicine, University of Miami School of Medicine, Miami.

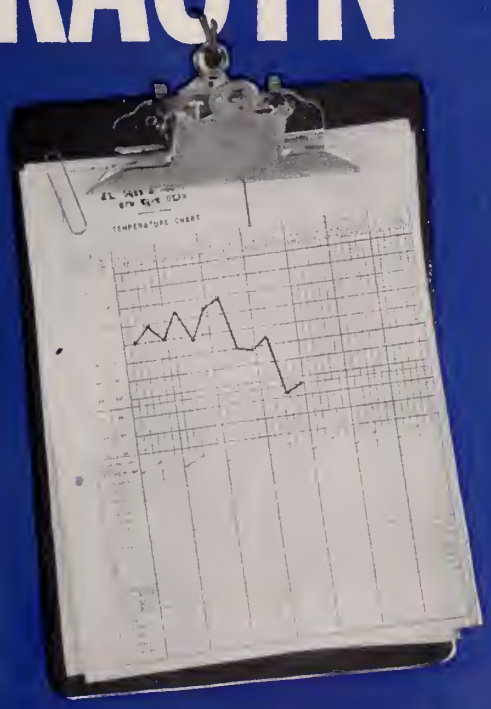
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A reportedly higher incidence of gastric distress in patients receiving the newer steroids prednisone and prednisolone indicates the desirability of co-administering non-systemic antacids.[1]

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'Co-Deltra' and 'Co-Hydeltra' are trade-marks of Merck & Co., Inc.

1. Bollet, A. J., Black, R., and Bunim, J. J.: *J.A.M.A.* **158**: 459, June 11, 1955.

'Co-Hydeltra'

Prednisolone Buffered

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All pure coffee...
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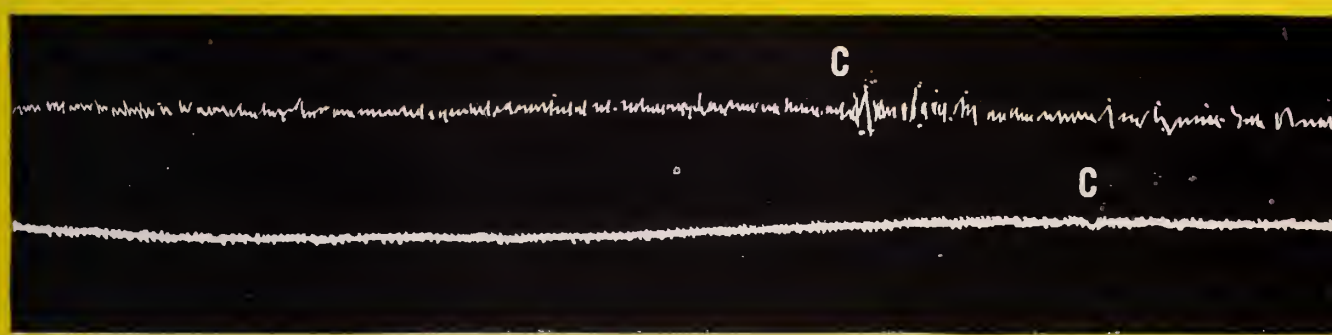
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Supplied: Tablets, 400 mg., bottles of 50.

1. Dickel, H.A., et al.: West. J. Surg., April, 1956.

anti-anxiety factor with muscle-relaxing action ... relieves tension

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COMPONENT SOCIETY NOTES

Alachua

Dr. Thomas H. Maren, head of the Department of Pharmacology, J. Hillis Miller Health Center, University of Florida, was principal speaker at a recent meeting of the Alachua County Medical Society held at the Gainesville Golf and Country Club. Dr. Maren's subject was the role of the pharmaceutical industry in medical research.

Indian River

The Indian River County Medical Society has paid 100 per cent of its state dues for 1956.

Lee-Charlotte-Collier-Hendry

Drs. William H. Grace and John C. Vinson, both of Fort Myers, have been honored by the Lee-Charlotte-Collier-Hendry County Medical Society for their 50 years in the practice of medicine. Presentation of bronze plaques to Drs. Grace and Vinson took place during the Society's March meeting held at the home of Dr. H. Quillian Jones at Fort Myers.

Dr. Joseph L. Selden Jr., president of the Society, presented the plaque to Dr. Grace, and Dr. Jones presented the plaque to Dr. Vinson.

Dr. Grace has practiced at Fort Myers for 32 years. Dr. Vinson, who was president of the Florida Medical Association in 1924, practiced at Tampa before moving to Fort Myers seven years ago.

Nassau

The Nassau County Medical Society has paid 100 per cent of its state dues for 1956.

Hillsborough

Dr. Michael G. Mulinos, medical director, Commercial Solvents, was guest speaker for the March meeting of the Hillsborough County Medical Association.

Pasco-Hernando-Citrus

Dr. Richard G. Connar, of Tampa, was principal speaker for the February meeting of the Pasco-Hernando-Citrus County Medical Society held at the Ruehl Rest Home, San Antonio. Dr. Connar's subject was "Advanced Cardiac Surgery."

Polk

Dr. William Arrowsmith, head of the Department of Medicine, Ochsner Clinic, New Orleans, was guest speaker for the March meeting of the Polk County Medical Association. The meeting was held at the Lakeland Yacht and Country Club.

Dr. Arrowsmith discussed the present status of lymphomas and leukemia.



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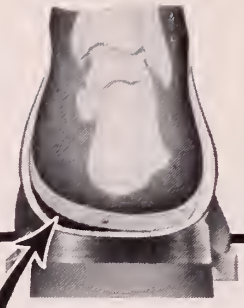
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*Fishberg, A. M.: Hypertension and Nephritis, ed. 5, Philadelphia, Lea & Febiger, 1954, pp. 177-178.

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Volusia

Drs. J. Rocher Chappell and James D. Moody, of Orlando, were guest speakers for the March meeting of the Volusia County Medical Society.

Dr. Chappell, medical advisor to the Orange County Civil Defense Unit, discussed the duties of physicians in a possible atomic bomb attack. Dr. Moody's subject was vascular surgery. It was illustrated by slides and a motion picture.

Duval

"The Doctor Goes to Court" was the principal topic for discussion at the April meeting of the Duval County Medical Society held at Sellers Auditorium.

Sitting as a panel were Drs. Raymond R. Killinger and George I. Raybin, Judge Charles Luckie and Attorneys Patrick Conroy and Jack Wayland, all of Jacksonville.

The program was arranged by Dr. J. Champneys Taylor, chairman of the Program Committee.

OBITUARIES

Reuben Nathaniel Burch, Senior

Dr. Reuben Nathaniel Burch Sr., of Miami, died on Jan. 7, 1956. He was 72 years of age.

Born in Laudersville, Ala., in 1883, Dr. Burch was educated in his native state. He received his academic schooling at Florence State Teachers College and his medical training at the University of Alabama School of Medicine, where he was awarded the degree of Doctor of Medicine in 1910. During World War I he served as a captain in the Medical Corps of the United States Army and was on the local selective service board in World War II.

Dr. Burch practiced medicine in Lakeland, Ga., prior to locating in Miami in 1925. His specialty was obstetrics. From 1932 through 1944 he was chief of obstetrics at Jackson Memorial Hospital and in 1925 he served as chief of staff there. Also he was on the staff of Victoria and Mercy hospitals. A member of the Central Church of Christ, his official post was that of an elder for many years.

Dr. Burch was a member of the Dade County Medical Association, serving as its president in 1937. For 28 years he held membership in the Florida Medical Association. He was second vice president in 1937 and served as a committeeman at various times. He also held membership in the

Meat...

and the Rehabilitation of Protein Depleted Patients

Although the recommended daily allowance of one gram of protein per kilogram of body weight is adequate for the average healthy adult,[1] greater amounts may be needed in the rehabilitation of patients depleted in protein after severe infections, mechanical trauma, burns, or extensive surgery.[2] Protein needs for tissue regeneration during convalescence are high.

To speed rehabilitation of the protein depleted patient, top quality protein and calories should be given in generous quantity.[2] However, a high protein intake, 130 grams daily, at best induces a slow response.[3] Intakes at 3 or 4 times that level may produce considerably more rapid gain in weight, strength, and morale.[4,5] If mastication and swallowing are difficult, canned strained meats—such as used in infant feeding—may be used to advantage in the high protein diet.[2]

Lean meat, outstanding in contained top quality protein, may well be made the keystone of the high protein diet. Its abundance of vitamin B complex and essential minerals—iron, phosphorus, potassium, and magnesium—adds to its therapeutic value. Important also are its appetite appeal, its easy digestibility, and its virtual freedom from allergenic properties.

1. Recommended Dietary Allowances, Washington, D. C., National Academy of Sciences—National Research Council, Publication 302, 1953.
2. Co Tui: Review: The Fundamentals of Clinical Proteinology, J. Clin. Nutrition *1*:232 (Mar.-Apr.) 1953.
3. Keys, A.; Brozek, J.; Henschel, A.; Mickelsen, O., and Taylor, H. L.: The Biology of Human Starvation, Minneapolis, Univ. of Minnesota Press, 1950.
4. Burger, G. C. E.; Drummond, J. C., and Sandstead, H. R.: Malnutrition and Starvation in Western Netherlands, The Hague General State Printing Office, 1948, Part II, p. 91.
5. Co Tui; Kuo, N.H.; Chuachiaco, M., and Mulholland, J.H.: The Protein Depletion (Hypoproteinia) Syndrome and Its Response to Hyper-Proteinization, Anesth. & Analg. *28*:1 (Jan.-Feb.) 1949.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

American Meat Institute
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American Medical Association and his specialty organizations.

Surviving are the widow, Mrs. Lizzie Patten Burch, of Miami; three sons, Dr. Reuben N. Burch Jr., and William Thomas Burch, both of Miami, and Jack Burch, of Tampa; one daughter, Mrs. Sue McMahan, of Nashville, Tenn.; six sisters, and four brothers.

Claude Clifford Pearce

Dr. Claude Clifford Pearce of Mulberry died in Tampa on Dec. 30, 1955. He was 78 years of age.

Dr. Pearce was born in Chambers County, Alabama, on March 27, 1877. He was awarded the degree of Doctor of Medicine by the Atlanta College of Physicians and Surgeons, now Emory University School of Medicine, in 1907 and then served an internship at Grady Hospital in Atlanta.

Coming to Florida in 1909, he located in Polk County. For two years he engaged in the general practice of medicine at Christina and thereafter in Mulberry. During the 46 years that he served the county as a general practitioner, he saw it grow from a sparsely settled region to its present prosperity and made a vital contribution to its progress. In the southwestern section comprising the communities of Mulberry, Brewster, Bradley, Pearce, Nichols, Medulla, and their environs, this beloved family doctor was through the years perhaps its best known citizen and certainly one of its most revered. Locally, he was for years a member of the School Board, and his advice on civic matters was constantly sought by community leaders.

Dr. Pearce was a member of the Polk County Medical Association. Since 1925 he had been a member of the Florida Medical Association and held honorary status at the time of his death. Through the years he was also a member of the American Medical Association.

In 1911, Dr. Pearce was married to Miss Nettie Whitaker, who died several years ago. Surviving are one son, Lt. Col. William W. Pearce, of Mulberry; and one daughter, Mrs. Mary Friedman, of Colorado Springs, Colo.

A total of 354,445 earned degrees were granted by the nation's colleges and universities during 1954-55. This is a smaller number than were earned during 1953-54. Of the 354,445 total, 22,229 were in healing arts and the medical sciences, the third largest field of study.



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the patient with nonspecific rheumatism

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MRS. BURNS A. DOBBINS JR., Nominating..*Fort Lauderdale*
MRS. RICHARD F. STOVER, Writer for Fla. Med. Journal*Miami*

A Message from the President

This year has been a memorable one for the Florida Medical Auxiliary. It has initiated a program primarily educational, the sole purpose of which was to bring to the attention of the women of the Auxiliary, the policies and problems of the local medical societies in relation to health and medical care.

The fact that this program has achieved a measure of success can be attributed to innovations instituted at the Post-Convention Board Meeting held in St. Petersburg, and the Fall Conference at Ponte Vedra. At the Post-Convention Board Meeting a chart was presented to all county presidents to be used as a guide in their work for the year. This chart was a reminder that our Auxiliary was not just another ordinary woman's club, but a live, invigorating organization infused with a resolve to augment the programs of the medical society from which our birthright was obtained. It was indeed most gratifying to me on my visits to the county auxiliaries to find the presidents making the most from these charts in their endeavor to carry out the purpose and aims of our organization.

At the Fall Conference, where 34 members representing 20 out of 23 counties were present,

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Sturdy growth of the infant and resistance to disease depend largely on nutritional status.

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*Moyer, J. H., and Hughes, W. M.:
J. Chron. Dis. 2:678, 1955.

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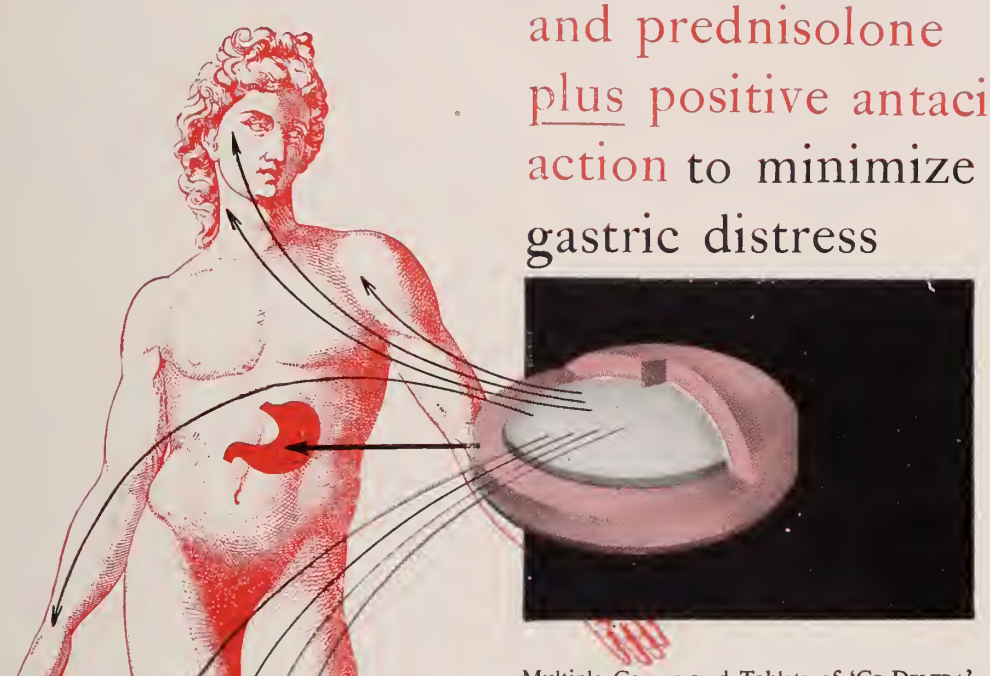
a novel departure was inaugurated. Kits containing printed material covering all phases of auxiliary work were issued to all. To all county presidents, their officers and board members was sent a complete set of notes covering the panel discussions, from nurse recruitment to the cost of medical care. This effort has not been in vain as expressed by the enthusiasm with which the program was received, and as reflected by members throughout the state. It is sincerely hoped that the program will be continued.

During the past year, it has been my privilege to visit county auxiliaries throughout the state. It was most heartwarming to find our first objective, namely, that of cultivating friendliness and promoting understanding, being carried out everywhere with sincere enthusiasm. The reports I was privileged to hear indicated the endeavor of the Auxiliary to assist our doctors of medicine in their program for the advancement of medicine and public health.

"Great oaks from little acorns grow" can be applied to our program this year. The success is a reflection of the part each member has played in her own way in her own community. Oak trees do not reach maturity in a year. Our program is far from being complete, nor can it ever be; for it is a progressive one. We have proven ourselves a valuable asset to the public relations program of our local medical societies. I have seen it work and I have seen its results. We are especially fitted and rightly situated to perform effectively our role in medical public relations. Let us firmly resolve to continue to do so.

The past year has been a most gratifying one for me. I have seen our Auxiliary in action. It is a powerful force and its might should be used to deter those who want to weaken the achievements of the medical profession. I have met many lovely people and I want to extend my appreciation for their generosities. To the committee chairmen, county presidents and individual members who have made this year a success I hereby express my gratitude. It goes without saying that without the wonderful cooperation of my board members and chairmen of committees the work of the auxiliary could not have been carried out. Whatever success our auxiliary has had in the past year is a reflection of the results of the combined efforts of all these individuals who gave of their time and effort unselfishly. To them my heartiest thanks. I also want to express my appreciation

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to Mr. Ernest R. Gibson, Managing Director of the Florida Medical Association for his understanding and cooperation. To Mr. W. Harold Parham, Assistant Managing Director and Supervisor of the Bureau of Public Relations, for his indulgencies and advice. I want to thank the Board of Governors of the Florida Medical Association and the executive office staff for their sympathetic understanding and wise counsel. I claim no credit for whatever success our Auxiliary has made this past year. It has been the effort of many people, and I want to thank them all. It has been my privilege to serve you and in so doing, that is my reward.

Mrs. Samuel S. Lombardo
President

BOOKS RECEIVED

Handbook of Pediatrics. By Henry K. Silver, M.D., C. Henry Kempe, M.D., and Henry B. Bruyn, M.D. Pp. 550. Price $3.00. Los Altos, Calif., Lange Medical Publications, 1955.

The practicing physician and the medical student will find in this Handbook a concise and readily available digest of the material necessary for the diagnosis and management of pediatric disorders. Emphasis is placed on the clinical aspects of the subject covered, but summaries of physiologic principles are included wherever necessary. This little volume, concise in format, is intended to supplement rather than to replace the more complete pediatric texts and reference works. Established concepts of pediatric diagnosis and treatment are in all cases given preference over the theoretic or experimental; however, recent advances are included wherever the authors deemed their inclusion suitable in a handbook of this type.

Dr. Silver is Associate Professor of Pediatrics, Yale University School of Medicine, New Haven, Conn.; Dr. Kempe is Assistant Professor of Pediatrics, University of California School of Medicine, San Francisco; and Dr. Bruyn is Assistant Professor of Pediatrics and Medicine, University of California School of Medicine, and Assistant Clinical Professor of Pediatrics, Stanford University Medical School, San Francisco.

Present-Day Psychology: *An Original Survey of Departments, Branches, Methods, and Phases, Including Clinical and Dynamic Psychology.* Edited by A. A. Roback. Pp. 995. Price, $12.00. New York, Philosophical Library, 1955.

This definitive volume of 40 original contributions embraces practically the whole range of psychology from the neurological basis to the military branch and parapsychology. Each chapter is written by an expert in his field expressly for this work. This survey is perhaps the most comprehensive in psychology, thus far, outside of an encyclopedia. While it is by no means exhaustive and not intended to be, it nevertheless is offered, not as representing a single trend, no matter how influential or prestige-laden, but rather as affording a fair view of all trends and topics.

This massive symposium is arranged in five divisions: Topical Department; Branches; Dynamic and Clinical Psychology; Methods, and Borderlands and Humanistic Psychology. Each of the 40 chapters has its bibliography, and there are diagrams, indexes and illustrations.





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Your patient may like cottage cheese whipped into milk flavored with chocolate and mint, or he can blend it with cranberry juice sparked with lime.

Strained carrots go in milk, broth, or pineapple juice. Flavor the milk blend with nutmeg, the broth with parsley, and the juice with cinnamon. An egg or skim milk powder may be added for a protein bonus.

Strained fruits in fruit juices do well with a squeeze of lemon or a touch of mint.

Then serve them up with dash—

Bright colored drinks look good in clear glass—pale ones in gayly painted glasses. And if a mixture looks drab, hide it in a bean pot or a round jam jar wrapped in a napkin.

Add a bright plastic straw. And for garnish, try a sprinkle of spice, a spoonful of sherbet, a dab of whipped cream, or a lemon slice hooked on the edge of the glass. Or frost the rim by dipping the glass in water, then sugar.

Of course, only you can tell your patient just which foods he can and must have. And if you feel that a glass of beer* is acceptable in his specific condition, it may provide the incentive he needs to stay within the limits you set.

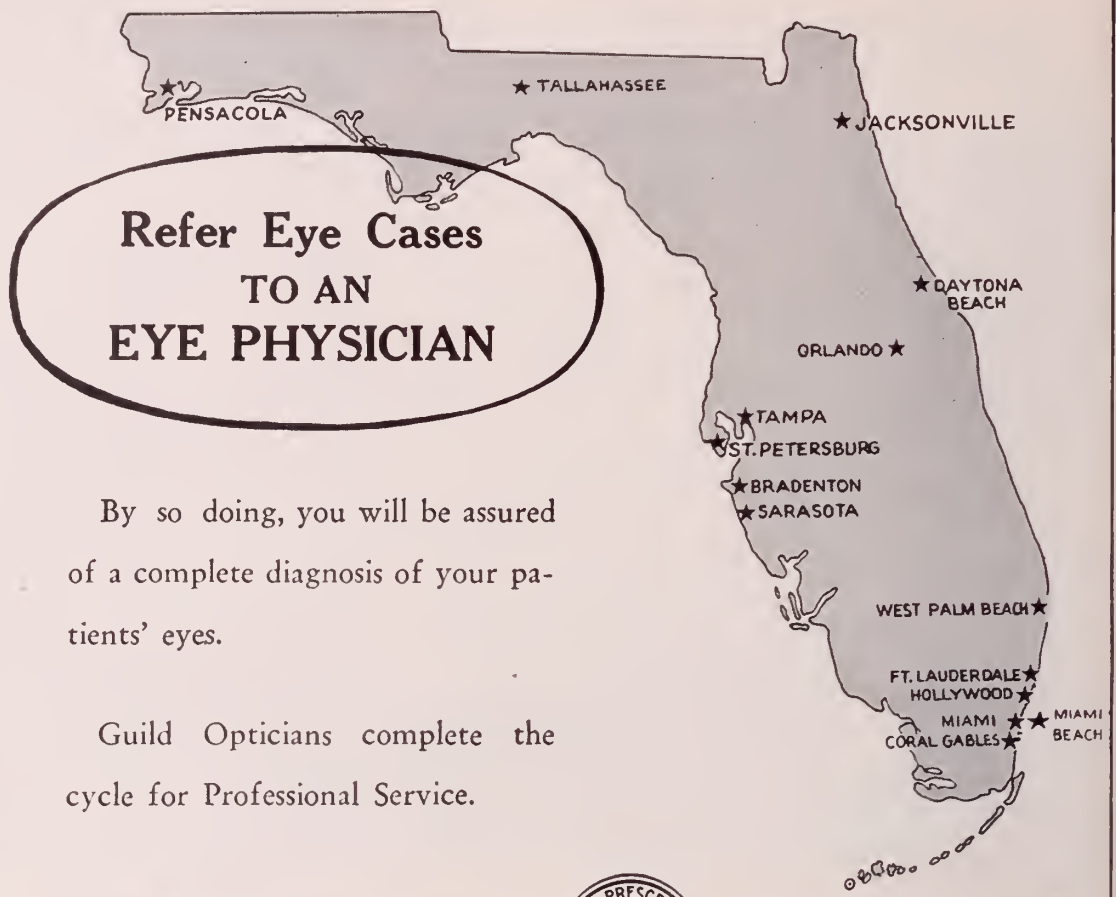


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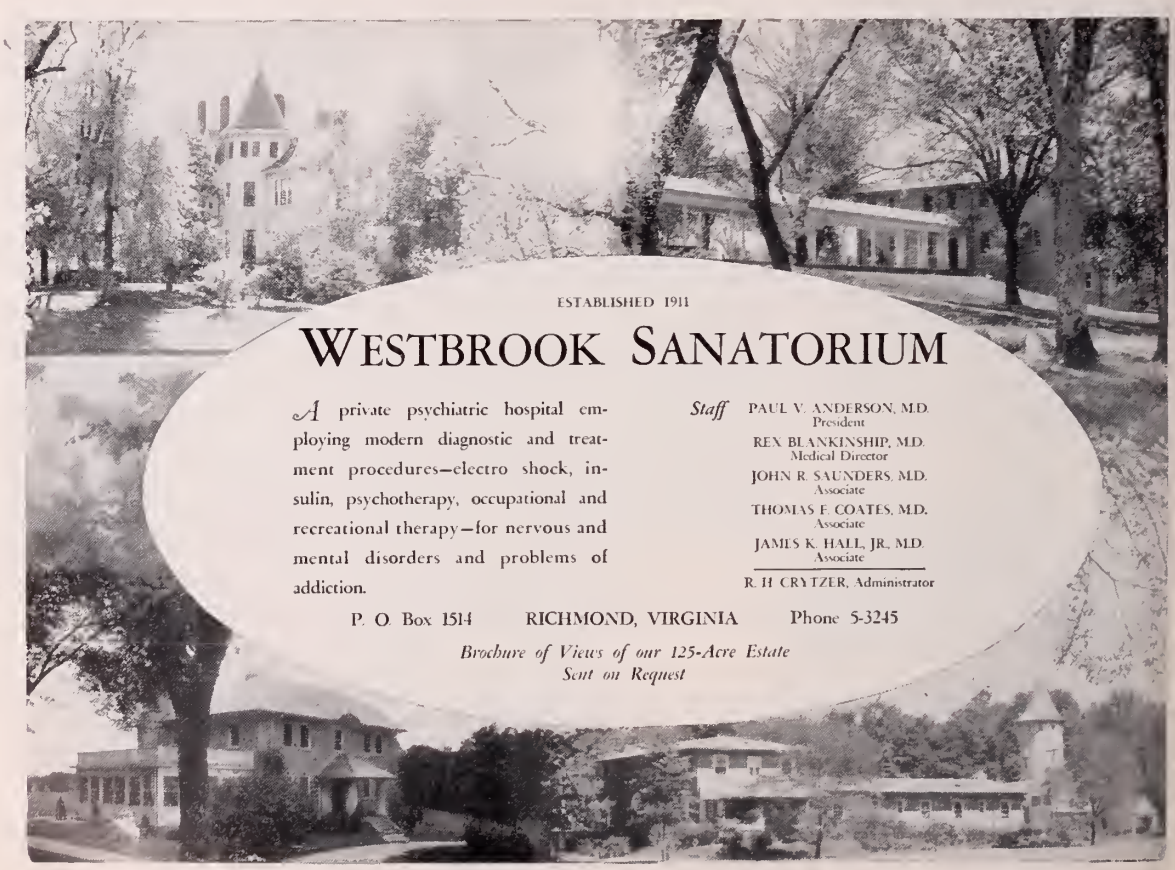
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A-Northwest	William P. Hixon, Pensacola	Walter J. Baker, Foley	Tallahassee
B-Northeast	Henry J. Babers Jr., Gainesville	Charles L. Park Sr., Sanford	Ocala
C-Southwest	C. Frank Chunn, Tampa	James R. Boulware Jr., Lakeland	Tampa
D-Southeast	James R. Sory, West Palm Beach	Ralph S. Sappenfield, Miami	West Palm Beach
Florida Specialty Societies			
Academy of General Practice	Frank T. Linz, Tampa	James B. Hodge Jr., Tampa	Miami Beach, May 13, '56
Allergy Society	W. Ambrose McGee, W. P. Bch.	Norris M. Beasley, Ft. Lauderdale	" " " "
Anesthesiologists, Soc. of	Wayland T. Coppedge Jr., Jax.	John T. Stage, Jacksonville	" " " "
Chest Phys., Am. Coll., Fla. Chap.	Hawley H. Seiler, Tampa	William L. Potts, Jacksonville	" " " "
Derm. and Syph., Assn. of	Joseph L. Hundley, Orlando	Kenneth J. Weiler, St. Petersburg	Miami Beach, May 12-13, '56
Health Officers' Society	Clarence L. Brumback, W. P. Bch.	Lorenzo L. Parks, Jacksonville	Miami Beach, May 13, '56
Industrial and Railway Surgeons	Frank L. Fort, Jacksonville	John H. Mitchell, Jacksonville	" " " "
Neurology & Psychiatry	Edward H. Williams, Miami	J. Robert Campbell, Tampa	Miami Beach, May 12-13, '56
Ob. and Gynec. Society	J. Champneys Taylor, J'sonville	Reuben B. Chrisman Jr., Crl. Gbls.	Miami Beach, May 13, '56
Ophthal. & Otol., Soc. of	Charles W. Boyd, Jacksonville	Kenneth S. Whitmer, Miami	" " " "
Orthopedic Society	Edward W. Cullipher, Miami	Robert P. Keiser, Coral Gables	" " " "
Pathologists, Society of	Millard B. White, Sarasota	Wray D. Storey, Tampa	" " " "
Pediatric Society	Wesley S. Nock, Coral Gables	Henry G. Morton, Sarasota	" " " "
Proctologic Society	Thomas F. Nelson, Tampa	George Williams Jr., Miami	Miami Beach, May 12, '56
Radiological Society	Hugh G. Reaves, Sarasota	Donald H. Gahagen, Ft. Laud'dale	Miami Beach, May 12-13, '56
Surgeons, Am. Coll., Fla. Chapter	Joseph S. Stewart, Miami	C. Frank Chunn, Tampa	Miami Beach, May 13, '56
Urological Society	David W. Goddard, Daytona Bch.	W. Dotson Wells, Fort Lauderdale	" " " "
Florida—			
Basic Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Miami, June 9, '56
Blood Banks, Association	Louis E. Pohlman, Orlando	Mrs. Estelle Lieberman, W. P. Bch.	Pensacola, May 26-27, '56
Blue Cross of Florida, Inc.	Mr. C. DeWitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	
Blue Shield of Florida, Inc.	Russell B. Carson, Ft. Lauderdale	John T. Stage, Jacksonville	Miami Beach, May 13, '56
Cancer Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	Miami Beach, May 13, '56
Clinical Diabetes Assn.	Sidney Davidson, Lake Worth	Edward R. Smith, Jacksonville	
Dental Society, State	T. A. Price, D.D.S., Miami	W. A. Buhner, D.D.S., Daytona B.	Miami Beach, May 28-30 '56
Heart Association	Victor H. Kugel, Miami Beach	Edwin P. Preston, Miami	Miami Beach, May 9-12, '56
Hospital Association	Mr. Robert B. Eleazer Jr., Jax.	Mr. Steve F. McCrimmon, C. Gbls.	
Medical Examining Board	Morris B. Seltzer, Daytona Bch.	Homer L. Pearson Jr., Miami	Miami Beach, June 24-26, '56
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 25-29, '56
Nurse Anesthetists, Fla. Assn.	Miss Dorothy Jackson, C. Gables	Mrs. Lulla F. Bryan, Miami	June 24-26, '56
Nurses Association, State	Martha Wolfe R.N., Coral Gables	Agnes Anderson, R.N., Orlando	Ft. Lauderdale, Oct. 22-24, '56
Pharmaceutical Assoc., State	Miss Frances Walpole, Sarasota	Mr. R. Q. Richards, Ft. Myers	Clearwater, May 20-23, '56
Public Health Association	Lorenzo L. Parks, Jacksonville	N. J. Schneider, Ph.D., Jax	
Trudeau Society	Harold W. Johnston, Orlando	Howard M. DuBose, Lakeland	
Tuberculosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mr. Ernest L. Abel, W. Palm Bch.	
Woman's Auxiliary	Mrs. Samuel Lombardo, J'sonville	Mrs. Leffie M. Carlton Jr., Tampa	Miami Beach, May 13-16, '56
American Medical Association	Elmer Hess, Erie, Pa.	Geo. F. Lull, Chicago	Chicago, June 11-15, '56
A.M.A. Clinical Session			Seattle, Nov. 27-30, '56
Southern Medical Association	W. Ray McKenzie, Balti., Md.	Mr. V. O. Foster, Birmingham	Washington, Nov. 12-15, '56
Alabama Medical Association	F. L. Chenault, Decatur	Douglas L. Cannon, Montgomery	
Georgia, Medical Assn. of	H. Dawson Allen Jr., Milledgeville	David Henry Poer, Atlanta	Atlanta, May 13-16, '56
S. E. Hospital Conference	Mr. D. O. McClusky Jr., Tuscaloosa, Ala.	Mr. Pat Groner, Pensacola	
Southeastern Allergy Assn.	Ben Miller, Columbia, S. C.	Kath. B. MacInnis, Columbia, S.C.	Charlotte, N. C., Oct. 5-6, '56
Southeastern, Am. Urological Assn.	Sidney Smith, Raleigh, N. C.	Robert F. Sharp, New Orleans	
Southeastern Surgical Congress	Donald S. Daniel, Richmond	B. T. Beasley, Atlanta	
Gulf Coast Clinical Society	E. T. McCafferty, Mobile, Ala.	Theo. Middleton, Mobile, Ala.	

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SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Active Members
Alachua	Albert G. Love IV, Gainesville	G. Leonard Emmel, Gainesville	2nd Tues.	53
***Bradford, Gilchrist, Union**				
Bay	Joseph H. Morris, Panama City	John J. Hollomon Jr., Panama City	1st Tues.	27
Brevard	Isabel Roberts, Melbourne	Jack T. Bechtel, Eau Gallie	2nd Tues.	35
Broward	Thomas F. Huey Jr., Fort Lauderdale	Anthony C. Galluccio, Hollywood	4th Tues.	121
Columbia	Thomas H. Bates, Lake City	Clifton G. York, Lake City	1st Mon.	11
***Baker**				
Dade	Hunter B. Rogers, Miami	Vincent P. Corso, Miami	1st Tues.	721
DeSoto-Hardee-Highlands-Glades	Merle C. Kayton, Wauchula	Roland W. Banks, Wauchula	1st Tues.	28
Duval	Joseph J. Lowenthal, Jacksonville	Charles F. McCrory, Jacksonville	1st Tues.	298
***Clay**				
Escambia	Gretchen V. Squires, Pensacola	Pascal G. Batson Jr., Pensacola	2nd Tues.	105
***Santa Rosa**				
Franklin-Gulf	Harold B. Canning, Wewahitchka	Photis J. Nichols, Apalachicola	Last Wed.	6
Hillsborough	James N. Patterson, Tampa	James A. Winslow Jr., Tampa	1st Tues.	196
Indian River	Vernon L. Fromang, Vero Beach	Enoch J. Vann Jr., Vero Beach	2nd Tues.	8
Jackson-Calhoun	Richard H. Schulz, Marianna	Francis M. Watson, Marianna	Quarterly	16
Lake	Geoffrey H. Binneveld, Leesburg	J. Basil Hall, Tavares	1st Wed.	25
***Sumter**				
Lee-Charlotte-Collier-Hendry	Joseph L. Selden Jr., Fort Myers	George D. Hopkins II, Fort Myers	3rd Mon.	37
Leon-Gadsden-Liberty-Wakulla-Jefferson	Robert H. Mickler, Tallahassee	Odis G. Kendrick Jr., Tallahassee	Quarterly	63
Madison	Candler K. Hayes, Madison	Wilmer J. Coggins, Madison		8
Manatee	Richard V. Meaney, Bradenton	Eugene E. Biel, Bradenton	2nd Tues.	29
Marion	William J. McGovern, Ocala	Robert L. Gibson, Ocala	3rd Tues.	30
***Levy**				
Monroe	Allen Shepard, Key West	William R. Ploss, Key West	1st Thurs.	14
Nassau		John W. McClane, Fernandina Beach	Last Fri.	10
Orange	Thomas C. Butt, Orlando	W. Ansell Derrick, Orlando	3rd Wed.	184
***Osceola**				
Palm Beach	Walter R. Newbern, West Palm Beach	Horace D. Atkinson, West Palm Beach	4th Mon.	147
Pasco-Hernando-Citrus	Gail M. Osterhout, Inverness	W. Wardlaw Jones, Dade City	2nd Thurs.	17
Pinellas	Daniel F. H. Murphey, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	214
Polk	James T. Shelden, Lakeland	Marion W. Hester, Lakeland	2nd Wed.	95
Putnam	Bennie J. Massey, Palatka	Bernard E. Kane, Crescent City	2nd Tues.	9
St. Johns	Reuben J. Plant Jr., St. Augustine	Roy E. Campbell, St. Augustine	3rd Tues.	21
St. Lucie-Okeechobee-Martin	Alfred J. Cornille, Fort Pierce	Adrian M. Sample, Fort Pierce	3rd Thurs.	26
Sarasota	Eugene D. Liddy Jr., Sarasota	Karl R. Rolls, Sarasota	2nd Tues.	57
Seminole	William V. Roberts, Sanford	Terry Bird, Sanford	2nd Tues.	19
Suwannee	Shirley L. Hadden, Live Oak	Hiram B. Curry, Jasper	1st. Sat.	11
***Hamilton, Lafayette**				
Taylor	Ralph J. Greene, Perry	John H. Parker Jr., Perry	Last Fri.	5
***Dixie**				
Volusia	Theodore F. Hahn Jr., DeLand	Achille A. Monaco, Daytona Beach	2nd Tues.	80
***Flagler**				
Walton-Okaloosa	Henry C. White Jr., Fort Walton Bch.	George W. Barrow Jr., Crestview	3rd Tues.	19
Washington-Holmes	Martin L. Lane, Chipley	L. H. Paul, Bonifay		3
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Severe Chronic Pruritus Vulvae
Robert N. Creadick

Ulcerative Colitis and Azulfidine Therapy
Joseph G. Seltzer

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Part II
Robert M. Thorner, M.B.A.
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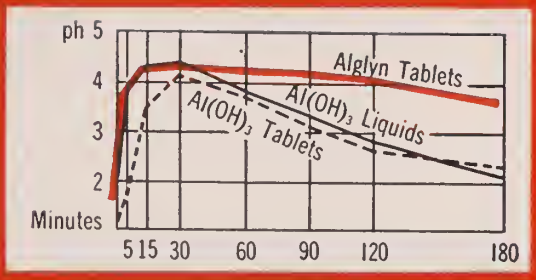
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1. Rossett, N.E. and Rice, M.L., Jr.: Gastroenterology, 26:490, 1954.
2. Hammarlund, E.R. and Rising, L.W.: J. Am. Pharm. Assoc., Scientific Edition, 38:586, 1949.

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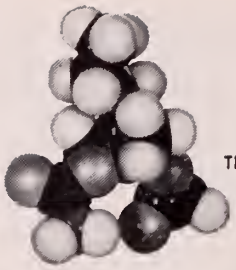
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1. Grayzel, H. G., Heimer, C. B., and Grayzel, R. W.: New York St. J. Med. 53:2233, 1953. **2.** Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediatrics 68:382, 1951. **3.** Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Ind. Med. & Surgery 18:512, 1949. **4.** Turell, R.: New York St. J. Med. 50:2282, 1950. **5.** Marks, M. M.: Missouri Med. 52:187, 1955.

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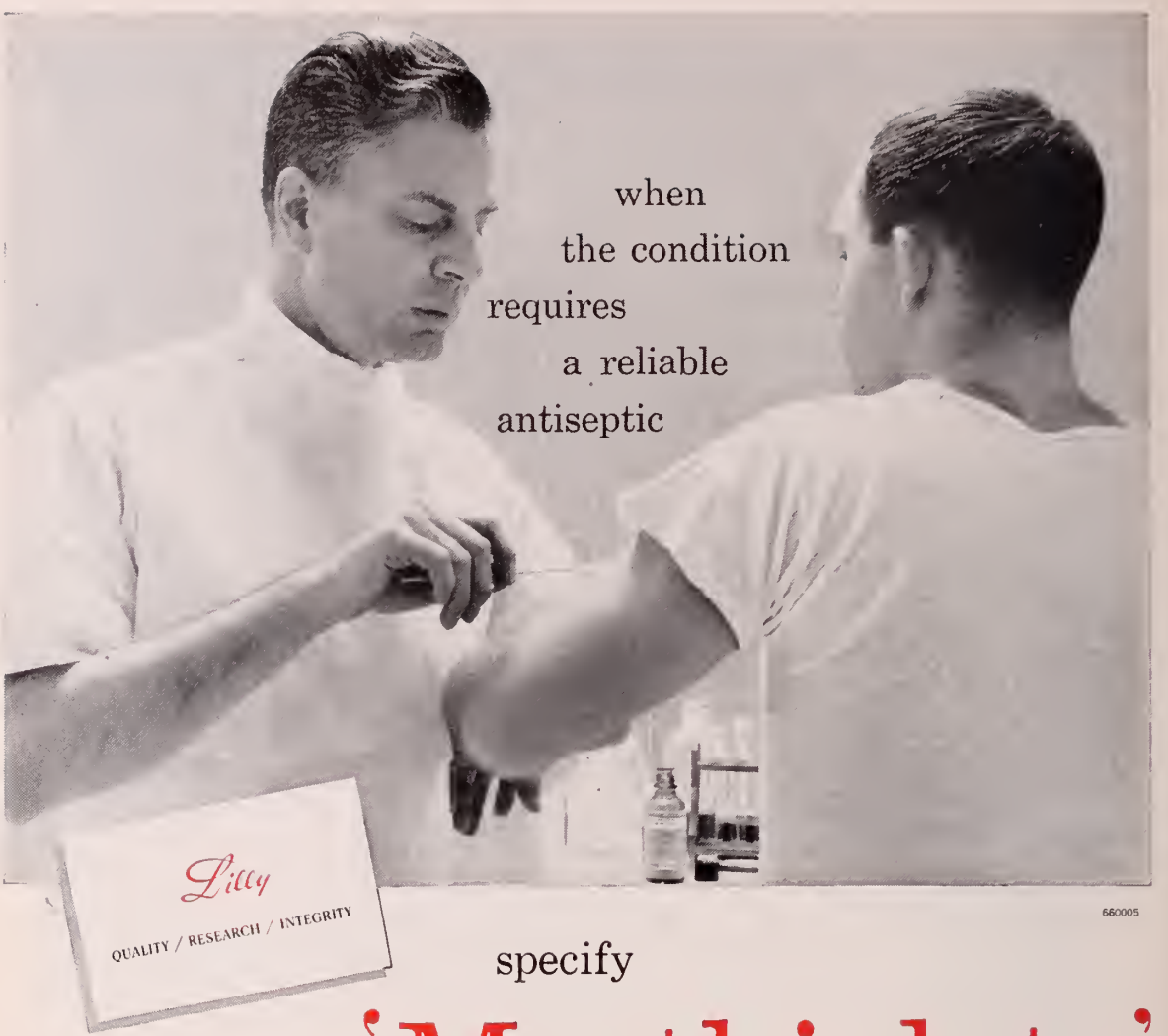
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The Journal of The Florida Medical Association
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Volume XLII | Jacksonville, Florida, June, 1956 | No. 12

Severe Chronic Pruritus Vulvae

Robert N. Creadick, M.D.
DURHAM, N. C.

If the frequency in numbers of treatments for a single condition were recorded, at the head of the list would be vulvovaginitis. It is more mistreated than menopause, contains almost as much drug addiction as cancer, makes suicide an occasional actuality, and its therapeutic path is traversed by gynecologist, dermatologist, radiologist, internist, surgeon, general practitioner, psychiatrist, urologist, and even pediatrician.

In at least 80 per cent of the patients the disease has its origin in Candida albicans (monilia), or trichomonas vaginitis, with a scattering of allergies, leukoplakia, atrophic vulvitis, condylomata acuminata, herpes, and chemical dermatitis. Parker, Jones and Carter in a recent paper discuss the particular problems of the geriatric group.

The interesting features seem to be that any patient who has this disorder longer than six months or a year has an accomplished fixation in that area. The separate manifestations and descriptions by the patient depend on her own pattern of reactivity. Any protracted instance may come from overtreatment, real or supposed guilt on the part of the patient, unexpressed hostility and resentment, or obvious disgust and disinterest on the part of the physician.

The therapeutic measures for so-called "leukorrhea" are actually few. When it is associated with pruritus, they should be concerned principally with trichomonas or monilia. Merely differentiating these two may solve the problem on the initial visit. Trichomonas, or the anaerobes associated with it, produces typically a foul, yellowish, watery and slightly foamy discharge. It is exaggerated around the time of menses, and maintaining an acid medium will usually suppress it. It is necessary for the patient to take douches while she is menstruating. Otherwise, the change in hydrogen ion concentration that occurs toward the alkaline side during menses will allow a return of the symptoms. If douches with lactic or acetic acid are taken, they should be cool. Heat seems to produce relief in some patients, but is followed by a rebound phenomenon of intense itching. Monilia on the other hand has its onset in the middle of the cycle, is characterized by heavy white discharge, most of which remains in the vagina and is not apparent to the patient. The principal symptoms will be external or vulvar rather than internal. It is no longer necessary to use gentian violet; the newer creams containing sodium acid propionate are preferred. The patient is instructed to take a plain cold water douche and then begin twice daily intravaginal applications of the cream with an inserter.

It is noteworthy that this disorder has become more and more common. Perhaps gynecologists were not aware of the causes originally. We still are not too sure of the pathogenesis. Since the advent of tetracycline drugs, fungus infestations (not infection) of the vagina and rectum have become a common sequitur. In fact, some companies dispensing these medicaments are now adding fungicidal material to the drug. The pruritus is intense, and occasionally a tremendous degree of edema accompanies it. The principal content of the discharge is not only mycotic, but the patient's own epithelium. This means the remaining surface is extremely raw and tender. The drug should rarely be used on the external skin lesions, if any.

Severe Chronic Vulvitis

Emphasis must be placed on the treatment of patients with severe chronic vulvitis. I am convinced that hormones are of no assistance either as suppository or cream. Roentgen therapy is definitely damaging to the tissue and the circulation, despite the fact that it will temporarily relieve the itching. It seems impossible to handle

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these patients without employing the psychogynecic approach. The stimuli responsible for the repeated recurrence of symptoms, certainly after several years' duration, are of emotional origin. As Lichtenstein stated, "The skin is a great mirror of physical and mental abnormalities. Both nervous system and epidermis have a common ancestry in the ectoderm."

Hailey, in 520 patients, found that the endocrine changes of the climateric were not the primary etiologic factors. Dunbar mentioned the connection between sexual feelings and tickling. The neurophysiology of tickle-itch-scratch-pain is extremely complicated. Publications by Wolff and Wolff, Zotterman, Rothman and a recent paper by Kepecs and Robin are pointing the way. Anxiety associated with masturbation, unexpressed hostility, incomplete orgasm, and even impotency in the male may produce a chain of symptoms referable to this area.

It is important, first, to complete the battery of tests necessary to detect vaginal flora and fauna, and biopsies for malignant disease if the appearance of the tissue warrants. These must be accomplished, however, by a detailed understanding of the patient, her family constellation, her personality structure. If the physician betrays his own disgust or anxiety to the patient, her guilt or concern will be deepened. If he runs the gamut of salves, potions, rinses and douches, he will certainly lose the confidence of the patient, but we hope will become inquisitive about his own inability to treat the patient. Careful examination, sympathetic serious attention, and quiet listening are essential. Short term psychotherapy must be employed to lessen the symptom. Suggested operation or strong antiseptics will be detrimental and further fix the symptom. Initial remarks by the doctor, if importunate, may be disastrous. Quoted examples would be: "Where on earth did you catch this?" or "The last woman I had with this trouble ended in the booby hatch." These exhibitions of the physician's ignorance or anger have no place in medical therapeutics. The first remark intensifies any guilt, supposed or actual, that the patient may have. The second, if she is depressed, will certainly make her more depressed.

Relief for the patient is our primary duty. The program of management should include tangible signs of the doctor's empathy, such as moderate nonnarcotic sedative drugs. In most of the severe vulvitis of long standing, the pruritus will be much worse at night. This is additional evidence of the large emotional component, but does not mean that general treatments of a relief-giving measure should be withheld. Drying of the vulva with any nonallergenic power is most useful during hot weather, and at night a cold Sitz bath containing ordinary clothing starch will certainly reduce the burning and itching. An easy formula for this procedure is to use 4 handfuls of "Linit" (clothing) starch in 4 inches of cool water in the tub. For continuous daytime job activities, some patients prefer a bland nonspecific like zinc oxide ointment applied liberally to the vulva. It is important that the patient not interpret this as specific therapy for a particular condition. It is only a temporary expedient for relief while the total problem is being worked out.

Much of the medical literature on vulvitis claiming substantial "cures" will not stand the test of time. Many reports contain a 30 per cent that shows in the protocols remarks like: (a) refused operation, (b) would not follow treatment, (c) did not appear for return examination, (d) anxiety neurotic, (e) no follow-up, and (f) "18 cases failed to respond." Obviously, we all encounter patients who are mentally so ill they require early psychiatric referral. One should automatically be suspicious of any patient whose symptom has persisted for six months or longer. It has been said of us: "In disease Medical Men guess; if they cannot ascertain a disease, they call it nervous." This was written in his medical class notebook by the poet John Keats 250 years ago. Nevertheless, if the location of the symptom happens to be the vulva, we, as gynecologists, will be required to see the patient. Observing the evolution of a resident physician's attitude in regard to his vulvitis patient on the charity ward is most rewarding. He will insist that the cure means vulvectomy, and add the description of a few leukoplakic spots which will undoubtedly "lead to cancer." The operation is often done, and with the support of the upper staff, only to have the lesion reappear exactly adjacent to the removed tissue.

It is hoped that the adoption of the aforementioned attitudes and regimen will enable us to handle these patients not more efficiently, but certainly more successfully and in more humane fashion.

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Aerosol Trypsin in Atelectasis Neonatorum

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Atelectasis of the newborn, or incomplete expansion of the air-bearing tissues of the lung, is a physiologic condition before birth. The fetal lung, on microscopic examination, has its air spaces undistended, and it looks more like a gland than an organ of respiration. It is sufficiently compact to sink on being placed in water, in contrast to the expanded postnatal lung which floats. It is only at birth that the lung expands (along with other changes in the cardiorespiratory system) and the condition of atelectasis of the newborn becomes pathologic and not physiologic. With these facts in mind, however, it must be realized that the entire lung does not become fully inflated with the institution of respiration. For the first seven to 10 days there are likely to be, in the normal infant, small areas of lung which are uninflated. After the first two days, these uninflated areas should be reasonably small.

For atelectasis to develop in a lung or part of a lung three requirements must be fulfilled.[1] Some mechanical cause of obstruction of the air-bearing passages must be present. There must be sufficient circulation behind the obstruction to absorb residual air, and there must be no accessory passages permitting air to enter the lung distal to the obstruction. In the newborn, of course, there must be simply obstruction.

In the normal lung there are several mechanisms to protect against atelectasis. These are: the mucous coating of the bronchi, collateral channels of respiration, the cough reflex and the action of the cilia to remove secretions.

The ability of ciliary action to remove secretions is roughly inversely proportional to the viscosity of the mucous coating of the respiratory tree. The glands of the bronchial mucosa are both mucous and serous. Buhrmester[2] demonstrated a direct relation between the mucin content of secretions and their viscosity. In a variety of conditions, such as chronic irritation, inflammation, allergy, dehydration, and infection, there is an increased secretion of mucin and a consequent increase of the viscosity of bronchial secretions.

"It is also worth recognizing that sputum coughed up is not necessarily an index of the type of bronchial mucus or exudate occluding a segment or lung. It may rather represent an overflow from the mouth of the bronchus of the affected lobe, even though the bronchus itself is completely occluded. Further, the concept of obstruction of the large bronchi by discrete, essentially solid, plugs is rarely found in actual practice. Instead, the occlusion of small bronchi and bronchioles by viscid secretions is more generally seen."[1]

My interest in respiratory problems of the newborn began during an internship at the City Hospital in Mobile, Ala. Dr. E. E. Gimenez at that time was running a controlled clinical trial on the use of a wetting agent called Alevaire. This product, developed by Dr. Joseph B. Miller, was proved by Dr. Gimenez to be of great value in the respiratory problems of pediatrics; it has since come to be widely used in all types of pulmonary disease. My observations under the guidance of Dr. Gimenez impressed on me that this was a remarkable advance in therapeutics and that the field of aerosol therapy should be explored further for agents as complementary or ancillary aids to Alevaire.

Shortly thereafter, I read an article[3] which directed my attention to proteolytic enzymes. There followed clinical and laboratory work which has been reported previously.[4] Expansion of that work which has since been carried out is the subject of this report.

Laboratory Observations

PROTEOLYTIC ENZYMES. — Sputum is composed of a number of organic substances in aqueous solution, the chief one of which is protein.[5] The major portion of the salivary protein appears to be a mucin, and it is mucin which is primarily responsible for the viscosity of saliva. Mucin is a glycoprotein, the carbohydrate of which is glucosamine and the prosthetic group an albumin. A proteolytic enzyme, then, must attack the albumin portion of the mucin molecule to effect a decrease in sputum viscosity. An increase in the nonprotein nitrogen to accompany the decrease in viscosity of the sputum should result. This was found to be true (table 1).

Papain, too, produces a decrease in viscosity of sputum (table 1). Clinical trials using this drug in aerosol form were discontinued after frank hemorrhage from the respiratory tract resulted in two cases. This drug also was reported by Unger and Unger[6] as causing hemorrhage from the respiratory tree.

Ficin is another proteolytic enzyme in which I was interested. My inquiries as to its availability were fruitless. Meanwhile, my experience with papain had lessened my enthusiasm.

OTHER ENZYMES. — Streptokinase-streptodornase (Varidase - Lederle) has been reported by Craven[7] as being noneffective in atelectasis. My observations (table 1) on its lack of ability to lower the viscosity of mucus confirm his finding. The explanation is simple. Streptokinase and streptodornase are not enzymes but proenzymes and require the presence of blood to be activated.[8]

Hyaluronidase (table 1) also lacks the ability to lower the viscosity of mucus. Because it is a "spreading factor," some physicians[9] are using it in atelectasis. Its basic biochemical function, however, which is breaking down complex carbohydrate polymers, seems to mitigate against any rational use of hyaluronidase in obstructive atelectasis due to mucus.

ETHYL ALCOHOL. — The efficacy of ethyl alcohol in vapor form as a treatment for pulmonary edema has been reported.[10] In this type of therapy its ability to lower surface tension is utilized. Because mucus is a glycoside (glycoprotein), theoretically it should be soluble in alcohol. Aerosol (vapor) alcohol then should loosen mucus plugs by dissolving them at least around the periphery. This effect was obtained in case 6 of the series here reported, but unfortunately a ball-valve effect was produced, and the patient became even more critically ill from bronchial obstruction. This approach has been abandoned.

Aerosol Trypsin in Atelectasis Neonatorum

In an antecedant article,[1] a preliminary report

Table 1. — Action of Enzymes on Respiratory Mucus

Enzyme Used	Trypsin 250,000 Armour Units	Papain 0.1 Gm.	Varidase Streptokinase-Streptodornase	Hyaluronidase 1500 TRU
Viscosity (cp)* before digestion	1.713	1.789	1.203	1.281
Viscosity (cp) after digestion	1.117	0.968	1.203	1.281
Nonprotein nitrogen before digestion	54			
Nonprotein nitrogen after digestion	70.2			
Change	0.596 cp 35 per cent	9.821 cp 48 per cent	0	0

*Cp, centipoise.

was made on the use of aerosol trypsin in atelectasis neonatorum. The technic described in that article has since been altered. I still use the unit consisting of 250,000 Armour units of trypsin, diluted with 25 cc. of Sorensen's phosphate buffer solution, because in my experience, the specially packaged (3 cc.) unit of aerosol trypsin (Armour) did not nebulize an adequate length of time for penetration of the respiratory tree by trypsin particles. Now I use the DeVilbiss No. 840 or 841 nebulizer.

The aerosol solution is prepared by adding the buffer solution to the trypsin powder. This solution, in the original bottle, is then lowered by means of a hemostat or similar instrument into the DeVilbiss No. 840 bottle and the fluid tube lowered into the aerosol solution. This procedure assures easy and complete delivery of the aerosol solution (fig. 1) to the incubator or other closed receptacle containing the infant.

It is my present policy to use aerosol trypsin only in infants with respiratory obstruction, presumably due to mucus, in whom tracheal catheterization and oxygen with Alevaire for a two hour period have not effected relief of the respiratory obstruction.

Aerosol trypsin has been used now in a total of 16 cases. These cases are summarized in table 2. All of the infants were critically ill. Of the 16 babies, five died (diagnoses listed in table 2), two received no help (diagnoses in table 2), three produced small to moderate amounts of mucus and were cured by gradual expansion of the lung, and six manifested rapid, dramatic cure with production of loose stringy mucus and rapid pulmonary ventilation. Representative cases are presented.

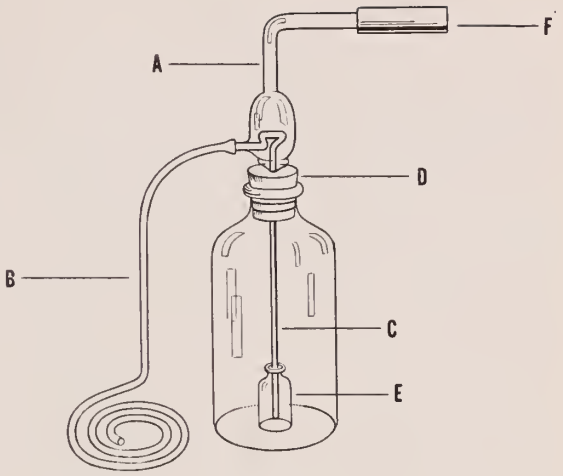


Fig. 1. — DeVilbiss No. 840 nebulizer with aerosol trypsin. A, pyrex glass nebulizer; B, air tube; C, fluid tube; D, rubber collar; E, trypsin solution; and F, vapor extension tube.

Table 2. — Summary of Cases of Atelectasis Neonatorum Treated with Aerosol Trypsin

Case No.	Weeks Gestation	Birth Weight	Age When Aerosol Trypsin Started	Results	Final Diagnosis
1	32	4 lb., 8 oz.	Birth	Death	Prematurity atelectasis
2	40	6 lb., 6 oz.	Birth	Rapid cure	Atelectasis
3	40	6 lb., 6 oz.	Birth	Death	Congenital absence of kidneys
4	38	5 lb., 7 oz.	12 hours	Gradual cure	Atelectasis
5	36	4 lb., 2 oz.	6 hours	Gradual cure	Atelectasis
6	40	6 lb., 8 oz.	5 hours	Gradual cure	Atelectasis
7	35	6 lb., 8½ oz.	Birth	Rapid cure	Atelectasis
8	40	5 lb., 7 oz.	Birth	Rapid cure	Atelectasis
9	40	5 lb., 12 oz.	6 hours	Death	Brain hemorrhage
10	32	4 lb., 14 oz.	12 hours	Rapid cure	Concussion
11	40	6 lb., 12 oz.	4 hours	Death	Atelectasis erythroblastosis
12	34	5 lb.	22 hours	Rapid cure	Atelectasis
13	34	4 lb., 3 oz.	2 days	Much mucus, no help	Subarachnoid hemorrhage
14	40	6 lb., 8 oz.	12 hours	Rapid cure	Atelectasis
15	36	4 lb., 10 oz.	Birth	No help	Drug depression
16	24	Not weighed	Birth	Death	Atelectasis, prematurity

Report of Cases

Case 9. — This case represents a child who was not helped by aerosol trypsin. A 5 pound, 12 ounce Negro male infant was delivered from the left occiput anterior position spontaneously without a traumatic birth. He was cyanotic from birth, producing much mucus but never crying adequately. He was cyanotic all the first day despite the use of oxygen. Physical examination revealed a small infant with cyanosis and retraction intercostally, subcostally, and at the suprasternal notch. Poor breath sounds were heard over the lungs. The heart rate was rapid and regular, and the heart was not displaced. A tentative diagnosis of atelectasis neonatorum was made. Six hours after birth aerosol trypsin therapy was instituted without benefit to the patient. He was given adrenal extract every four hours and 300,000 units of procaine penicillin once. Aerosol trypsin therapy was given again the next day without benefit. On the day after birth there developed a high-pitched cephalic cry. Laryngoscopy revealed a normal larynx without obstruction. Tracheotomy was performed without benefit, and the baby died 56 hours after birth. Postmortem examination revealed brain hemorrhage. Sections of the lung (after two treatments with aerosol trypsin) were examined by three pathologists and were said to be unaffected by the trypsin therapy.

Case 6. — This case represents an infant who was only gradually cured by the adjunctive use of aerosol trypsin. A 6 pound, 8 ounce white male infant was delivered from the left occiput anterior position spontaneously after an uncomplicated labor. Fifteen minutes were required to start respirations, and the baby was cyanotic with much mucus in the oropharynx after breathing was begun. In the incubator he was lethargic and cyanotic without oxygen. On physical examination the infant was normal except for cyanosis when not receiving oxygen, decreased breath sounds over both lungs and suprasternal, intercostal and subcostal retraction.

Five hours after birth, the oxygen being given was bubbled through 70 per cent alcohol. After 70 minutes, productive cough began with thick mucus plugs being raised. On suction, large quantities of mucus were obtained. The baby's condition became alternately better and worse, however, apparently from the ball-valve effect produced by loosened plugs of mucus. Because of the critical respiratory status, this method of therapy was discontinued and aerosol trypsin therapy (3 cc. unit) given. Profuse loose watery mucus was produced shortly, but the baby was still cyanotic without oxygen. The oxygen then was humidified through water. Eight hours later, 15 hours after birth, another aerosol trypsin therapy (3 cc. unit) was given, this time without benefit. Delayed production of mucus occurred four and eight hours later, though this was not thought to be the result of any therapy.

Twelve hours later, 27 hours after birth, Alevaire was started with mucus being suctioned in large quantities four and five hours after Alevaire was started. The baby still was cyanotic without oxygen.

Conservative therapy consisting of clysis, penicillin and oxygen-Alevaire was maintained, the baby being discharged from the hospital as cured on the eighth day of life.

Case 12. — This case represents those children who obtained rapid dramatic cure by the use of aerosol trypsin.

A premature male Negro infant, whose birth weight was five pounds, was delivered from the left occiput anterior position after an apparently normal 34 weeks' gestation and uncomplicated early labor. His condition was poor at birth. Respirations were feeble and ineffectual, and cyanosis was present. Heavy mucous secretions were present in the oropharynx.

The pharynx was suctioned by means of a rubber bulb syringe, and central nervous system stimulants were administered intramuscularly (Coramine 1 cc., alpha-lobeline 1 cc.) without any noticeable effect. Physical examination soon after birth revealed that there was slight expansion of the left lung and little, if any, of the right lung. There were no breath sounds over the right lung field and weak distant ones over the left. A diagnosis of bilateral atelectasis neonatorum was made at that time.

The infant was placed in a warm crib with the feet elevated and was given oxygen by mask at the rate of 6 liters per hour. A nurse was in constant attendance and suction was frequently employed, but little mucus was obtained and no expansion of the lungs occurred. Procaine penicillin, 300,000 units, was also given intramuscularly. Twenty-two hours after birth, the baby was considered in a terminal state. He remained continuously cyanotic despite oxygen, and the lungs showed no further evidence of expansion. There was a suggestion of incipient sclerema neonatorum.

At that time aerosol trypsin therapy was instituted with the use of 250,000 Armour units of trypsin diluted with 25 cc. of Sorensen's phosphate buffer solution. Within 30 minutes there was decided improvement in the baby's condition. The oropharyngeal mucus became profuse and fluent, the cyanosis disappeared, and the lungs began to expand as evidenced by increased excursions and increased breath sounds. Constant suction was necessary to keep the oropharynx clear. After eight hours, both lungs were considered to be completely expanded, and the infant was given a formula feeding.

Progress thereafter was uneventful. No more respiratory difficulty was encountered, and the infant was discharged on the fifth day of life.

Discussion

Trypsin is a proteolytic enzyme with optimum activity between pH 8 and 9. It hydrolyzes the peptide linkage, breaking proteins and polypeptides into smaller peptides and amino acids. As an aerosol, it attacks the mucus secretions from the respiratory tree, digesting the mucus and causing a decrease in viscosity and an increase in the nonprotein nitrogen (polypeptides and amino acids). Because it also is irritating to some degree, it increases coughing and initiates bronchial secretions of a profuse watery nature. These results are desirable in the infant with atelectasis due to bronchial obstruction by mucus.

It is nontoxic, as evidenced by studies in rabbits[3] and by the microscopic section in the case presented herein.

Moreover, there is in every living cell an antitrypsinase[8] which prevents trypsin from attacking normal living tissue, keeping therapy with aerosol trypsin within the range of the physiologic. There have been reported some transient chills and fever caused by aerosol trypsin.[3] These were relieved by benadryl and theoretically should be prevented by it. I have had no experience with this sequela.

Aerosol trypsin, however, is not always helpful. For the newborn infant with respiratory difficulty it is not a panacea. In this current uncontrolled series, only six of 16 critically ill patients were cured by its administration. It must be emphasized that only in those patients with bronchial obstruction due to mucus is it of benefit. It is specific therapy for a specific condition.

Only in the presence of accurate diagnosis will its use insure a good prognosis. For the child who needs it, however, it may be life-saving. It is my current policy to use it as an ancillary aid to Alevaire after Alevaire has been used at least two hours and the infant fails to show pronounced improvement.

Summary

Atelectasis neonatorum due to bronchial blocking by mucus is discussed and its treatment with aerosol trypsin presented.

Laboratory work on the effect of trypsin, papain, hyaluronidase and streptokinase-streptodornase in sputum is presented. The use of alcohol vapor in pulmonary conditions is mentioned.

Sixteen cases of atelectasis neonatorum treated with aerosol trypsin and the technic used are presented and summarized. Representative cases are discussed.

Aerosol trypsin is a harmless specific treatment for a specific condition. Only those infants with bronchial obstruction due to mucus will be benefited by its use.

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Chronic Ulcerative Colitis and Continuous Azulfidine Therapy

Report of Case

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Chronic ulcerative colitis is a miserable affliction. It is a disease regarded as a manifestation of a constitutional disturbance that presents itself in many forms and in various degrees of severity of colon dysfunction. It is characterized by diarrhea, rectal urgency and rectal incontinence of varying degree. It is a disease that is on the increase and is becoming relatively more common. It is a serious disease.

In recent years literature has been accumulating rapidly regarding this disease. There are many different and radical opinions regarding its cause and treatment. Because these opinions come from qualified and frequently famous physicians, there is much variation in the treatment of chronic ulcerative colitis. This treatment is haphazard and unscientific. If failure occurs, treatment is changed from one method to another. Thus it runs from Bargen's vaccines through fever, sulfonamide drugs, antibiotics, steroids, and psychotherapy to radical surgery. The pendulum is so erratic and swings to such extremes that a world-famous gastroenterologist, as late as 1952, recommended paregoric and Kaopectate as the treatment of choice.

Clinicians, because of the chronicity of the problem, explain the disease on the basis of personality changes and emotional factors, and try to refer the patient to a psychiatrist. With the advent of an increasing number of surgeons and an increased tendency for experimental surgery, many patients, roughly 15 per cent, are being subjected to ileostomy, preferably with colectomy, many surgeons even going so far as to advocate

early colectomy to eradicate this disease in order to obviate a late complication of carcinoma. Surgeons and many clinicians tend to disregard the fact that chronic ulcerative colitis is considered to be a constitutional disease and they also disregard the fact that the high percentage of cases quoted in which cancer develops may be erroneous. As recently as November 1953, Felsen and Wolarsky emphasized the fact that in a series of 994 cases of chronic ulcerative colitis, carcinoma occurred in only 0.65 per cent of the cases. They also stated there was no relationship between the two diseases. Prophylactic surgery, therefore, is no reason for colectomy. Their further data included patients of varying ages and follow-up conditions. They showed control studies of similar groups in 12,025 general admissions without ulcerative colitis and revealed an incidence of carcinoma of 0.8 per cent. In their opinion, pseudopolyposis was but one state in the process, and they reiterated the previously expressed opinion that bits of pinched off mucosa caused these areas and that these were not true adenomatous polyps. True polyps are definitely neoplastic and exert a definite tendency to malignancy.

Etiology

The cause is unknown. Many theories regarding the etiology of chronic ulcerative colitis have been reported. Some have gained national and worldwide fame because of their theories regarding the cause of this disease. Since there is yet no known specific factor, however, each new theory with its own method of treatment has failed to produce uniformly good results. The special forms of therapy now available for treatment in accordance with each specific theory are inadequate. Because of the unknown etiology and the possibility that this is a generalized constitutional disease, patients suffering from this affliction should be treated in a broad clinical manner.

The most important theories regarding the etiology are as follows in order of increased importance:

1. Lysozyme Theory.—There is an elevated concentration of lysozyme in the feces of patients suffering from chronic ulcerative colitis. In vitro studies have shown that lysozyme has no dissolving effect on mucus, and there is evidence to prove that lysozyme is a production of pus cells. Today lysozyme is not regarded as a causative agent, and therapy directed to treat this etiologic factor has been a failure.

2. Deficiency Factors.—It has been thought that some deficiency in the secretions of the wall of the stomach or intestines may be the cause of this disease, and because of this theory, various preparations of hog's intestinal tract are being administered. Although good results have been claimed, in some cases the condition has been aggravated by these factors.

3. Psychosomatic Factors.—Many clinicians and practically all psychiatrists believe that psychosocioeconomic factors originate, maintain and "trigger off" chronic ulcerative colitis and its recurrences. It has been claimed that its onset occurs with a stressful life situation. A certain personality has been described. This is the immature, overdependent, submissive person who has a sense of guilt, resentment, or hostility and who has been dependent on father or mother. When this parent dies, chronic ulcerative colitis results.

On the other hand, it should be emphasized that in most patients with severe neuroses chronic colitis does not develop. Even in neurotic patients with highly irritable colon syndromes this affliction does not develop. Many people with the so-called "chronic ulcerative colitis personality," under severe and emotional strain, have no bowel trouble.

Bargen stated that seldom is evidence found of emotional disturbance preceding the onset of this disease.

Emotional factors can and frequently do follow the development of organic disease. As some observant doctor once noted, disease above the diaphragm tends for optimism and disease below the diaphragm tends for depression. There is little wonder that emotional upsets may occur when a patient has a miserable affliction and is handicapped by an organic disease.

Amazingly, the moment these patients begin to feel well and diarrhea and urgency are only under partial control, the depressed mental status immediately returns to normal.

4. Allergy. — Periodically, allergy has been claimed as a causative factor. Rowe advocated a specific diet devoid of wheat, meat, eggs and fruit. In 1949, Andresen re-emphasized the opinion that this serious problem is caused by allergy. He stated that he had found the infallible factor in the cause of the disease to be allergy, usually to foods, although occasionally pollens, dust, bacteria and endocrine secretions have been the allergens to which the patient becomes sensitized. This author added that once the irritating allergens

were discovered and removed, improvement was pronounced and rapid. It may be because of this that Paulson's method of treating by intravenous sugar, salt and water may obviate all food allergens for from seven to 14 days, and this factor may be the reason for the improvement seen in the patients. Theoretically, the colon can be like any other shock organ.

5. Infection.—This is the most important of the prevalent theories. Infection is believed to be the cause because the disease is primarily one of inflammation. The infectious agent, however, is unknown.

Felsen and Wolarsky claimed that the disease is due to bacillary dysentery. It has also been claimed to be due to a postamebic infection. In other words, it has been stated that chronic ulcerative colitis is a chronic resultant of these conditions.

Bargen claimed, without adequate proof, that the disease is due to a diplostreptococcus and stated that this is the specific etiologic factor.

Other organisms have been isolated and blamed. Even the colon bacillus, which is a normal bowel inhabitant, has been blamed.

Chronic ulcerative colitis is possibly, even probably, infectious, but the specific agent is unknown. The belief that the disease is infectious is further based upon the fact that many patients improve on various sulfonamide drugs and various combinations of these drugs, and occasionally on antibiotic therapy.

The advent of sulfonamide drugs brought hope that these substances would prove of great value in the treatment of ulcerative colitis; and good results were obtained in many cases with this form of therapy. Results varied in all probability because there were varying rates in resorption and consequently the varying local effect on the intestine.

In view of the resemblance between the clinical pictures of ulcerative colitis and rheumatic fever, investigation was directed to the various salicylates in the therapy of ulcerative colitis. The results were not convincing; nor did simultaneous administration of salicylates and sulfonamide drugs present any definite advantage, as was noted by Svartz. He found, however, that a drug containing salicylic derivative and sulfonamide was of tremendous therapeutic aid, and with the help of chemists prepared salicylazosulfapyridine, a combination of aspirin and sulfapyridine, known as Azulfidine.

Compounds of this kind have an affinity for connective tissue. This drug causes distinct changes in connective tissue of the colon in this disease. The importance of these findings is still unknown. The first clinical experiences with Azulfidine were reported from European hospitals, but since then the drug has been utilized in the United States.

In 1949 Bargen, of the Mayo Clinic, reported his first series, in which there was great improvement on this drug.

In 1950 and 1951 Bargen stated that his experience with this drug was most gratifying and that it was the preferred drug in the treatment of severe ulcerative colitis. It was also reported that the diarrhea of ulcerative colitis would cease within two or three days of treatment in certain cases. In other cases, the effect did not set in until after prolonged treatment.

The case described is one of serious chronic ulcerative colitis that has been present continuously for approximately 13 years. The patient has been treated continuously with every known form of therapy. This treatment has included low residue diets; elimination diets of the type recommended by both Rowe and Andresen; the various sulfonamide drugs, both soluble and insoluble; and all the known new antibiotics as each was introduced, including Terramycin and Chloromycetin and steroid therapy in the form of ACTH and cortisone. During all these years and during these varied treatments, the course of the disease was unrelentingly progressive, and as the years went by the condition became slowly more serious and more severe. Two years ago the patient was given Azulfidine therapy. Since that time there has been amazing improvement in his health and in his symptoms. He is not cured. Complete rehabilitation, however, has been carried out, and he is well and working full time.

Similarly, five other patients with a much milder degree of chronic ulcerative colitis have been treated with Azulfidine. Four of these patients are apparently cured; the other patient is improved.

The case here reported is of unusual interest because of the long duration, the chronicity, and the great improvement following the institution of a chemotherapeutic drug. Furthermore, the case is unusual in that the patient today is permitted a complete diet with a full choice and range of foods, including roughage such as salads and fresh fruit. The only food eliminated is milk.

Report of Case

The patient, a 48 year old white, professional man, today is in apparently normal health. About 13 years ago when he was in perfectly normal health, he experienced sudden morning rectal urgency with two or three urgent bowel movements each morning for approximately nine months, but felt well, lost no weight and continued to work. Although the stools were checked for parasites, none were found. Ten months after the onset of the continuous urgency, this patient noticed blood in the stool, streaky in character. At that time proctoscopy was performed; the bowel was friable and bled easily on being touched. There was no granulation of the mucosa. The rectal sphincter was tight.

One month later amebic cysts were found in the stool. The patient was immediately given a full course of Vioform therapy. This caused a complete remission of symptoms, and bowel habits became normal. Three months later rectal urgency recurred, and a second course of Vioform was given followed by a course of Diodoquin for 20 days. Again there was remission. Approximately two months later there was a recurrence of the urgency. He was then treated with amebacidal therapy of an intensive type. This therapy included a full course of emetine intramuscularly.

From that time on the patient had continuous morning urgency with three to four bowel movements in the morning. He continued to feel well and continued to work on a full time basis. In 1945, approximately three years after the onset of the disease, the patient was checked by Dr. Joseph Felsen, of New York City. The diagnosis of amebic dysentery was confirmed by again finding amebic cysts in the stool. The patient was given a course of Anayodin. This caused severe diarrhea, and the drug was discontinued.

From 1945 until 1952 the course of the disease became progressively more severe. Periodically amebic cysts would be found in the stool. In addition, proctoscopic examination showed the granular inflamed mucosa typical of chronic ulcerative colitis. Also, in and around 1952, stool cultures showed the presence of Salmonella choleraesuis.

During these years the patient was treated with sulfadiazine, sulfaguanidine, Sulfasuxidine, Terramycin, Chloromycetin, penicillin and several courses of emetine. In addition, during these years, because antiamebic therapy usually gave mild relief of symptoms, he found that he could partially control the rectal urgency by taking two Vioform tablets daily and continued to do so on a long term basis. During all these years he felt well and maintained his weight. Although there was a moderate amount of bleeding, the blood picture, including the sedimentation rate, remained normal.

In the spring of 1952, the patient began to experience severe diarrhea and had 10 to 20 bowel movements a day. These movements contained primarily brown stained mucus, discolored by blood with small amounts of feces, a form of intestinal discharge known as "intestinal sputum." There was no fever nor loss in weight. Because of the severity of the diarrhea, the patient was referred to Dr. Burrill Crohn and was hospitalized at the Mt. Sinai Hospital in New York City. There all stool analyses and all blood work gave negative results. The sedimentation rate was normal. Proctoscopic examination showed the typical inflamed granular mucosa typical of chronic ulcerative colitis. During the course of proctoscopy, however, a rectal biopsy was performed, a procedure that is strongly contraindicated.

Within 24 hours following the biopsy the patient requested discharge from the Mt. Sinai Hospital and was discharged the following day. He returned to his home town.

Forty-eight hours after the biopsy was performed, the patient became acutely ill. For the following five weeks he was kept in complete bed rest, given a low residue diet and treated with Chloromycetin, 2 Gm. daily. In 30 days he lost 30 pounds. He then gradually began to improve.

For one year, from 1952 to 1953, the patient averaged eight to 10 bowel movements a day with great urgency, both of the daily and nocturnal type. He had anemia of a moderate degree and an elevated sedimentation rate of about 30 mm. in 60 minutes by the Westergren method. He was fatigued, mentally depressed and spent 14 to 16 hours a day in bed. During this year he was treated with Formo-Cibazol, an experimental combination of formaldehyde and sulfathiazole. This drug was used sometimes by itself and sometimes in combination with Acthar Gel and cortisone, and gave definite improvement in general health and weight. The stools were less frequent and reverted from the watery type to a mushy stool. Mild to moderate bleeding was still present.

In September of 1953 the patient again began to have severe diarrhea of 20 to 30 stools a day following an infection of the upper part of the respiratory tract. He was admitted to the Johns Hopkins Hospital under the care of Dr. Moses Paulsen. There a complete diagnostic survey showed the patient to be suffering from severe chronic ulcerative colitis. The barium enema showed involvement of the whole colon and also a small portion of the terminal ileum. At that time he was advised to change his living standards and curtail all activity, and was also advised to secure psychiatric help.

Upon returning to his home town, the patient disregarded all of this good advice. In October 1953, because of the reports of Bargen, Morrison and Svartz, he was given Azopyrin or, as it is known today, Azulfidine. Two weeks after the institution of this therapy, he slowly began to improve in general health. Bowel movements became semisolid for the first time in many years. Furthermore, intense griping and the severe abdominal pain began to abate, and the number of bowel movements slowly decreased. The patient was treated with the recommended dosage of 1 Gm. of Azulfidine every four hours for a two week period. The course was again repeated after a two week rest period. The patient continued to improve. The drug was stopped following the second course.

Because there was a continuous tendency for relapse, however, and because the rectal urgency continued to recur, he was again treated with Azulfidine. In the past two years it has been found that this tendency for urgency could be controlled almost completely by giving 1 Gm. of Azulfidine daily on a continuous basis. He has been receiving this form of therapy for almost two years. Signs and symptoms of chronic ulcerative colitis persist, but he no longer has night diarrhea. He still has mild to moderate urgency and averages two to four bowel movements a day. There is practically no bleeding for long periods. When bleeding does occur, it is due to bleeding from hemorrhoids present for years and aggravated by straining.

The patient has gained back the 30 pounds he lost, works full time and is on a regular diet, eating everything but avoiding milk and condiments such as pickles. He does eat mustard and ketchup.

The blood picture has also improved. The hemoglobin and red blood cell count are a low normal; however, the sedimentation rate is still mildly elevated, and the last reading was 23 mm. in 60 minutes Westergren. The white blood cell count ranges between 6,000 and 8,000 with 6 per cent eosinophils.

Summary

Although there are many theories regarding the etiology of chronic ulcerative colitis, the cause is still unknown. The disease must be considered as the manifestation of a constitutional disturbance that varies in its degree of severity. There is a strong probability that the disease is infectious in origin, but the infectious agent is still unknown.

Of the many methods of therapy recommended, there is one that is relatively unknown. This

is treatment with Azulfidine, which is probably the best of all the drugs for this purpose. Because of the probability that the disease is similar in nature to rheumatic fever and rheumatoid arthritis in regard to continuous need for therapy, the patient in the case reported has been treated continuously for two years with decided improvement. No claim for cure is made for this patient; however, there has been great improvement in physical health and complete rehabilitation.

Conclusion

Until more is known about chronic ulcerative colitis the treatment by ileostomy and other surgery should be condemned in practically all cases. Psychotherapy should play little or no part in the treatment. Azulfidine is an excellent drug, and it utilization is justified in all true cases of chronic ulcerative colitis.

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Neonatal Mortality in Florida; A Statistical Analysis

Part II: Place of Birth and Attendance by Midwife or Physican

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The proportion of births attended by physicians in hospitals has been increasing steadily during the past two decades,[1] and this increase has been considered by many persons to be one of the more important factors responsible for the continued reduction in infant mortality.

In Florida, however, as in most southern states, a large proportion of nonwhite births continues to be attended by midwives or by physicians outside of hospitals. The number and per cent of resident live births in Florida in 1953 distributed by place of birth and attendant are presented in table 1.

For purposes of this study, Doctors of Medicine and Doctors of Osteopathy have been included in the category of "physicians." Midwives have been treated as a separate group. Naturopaths and nonmedical attendants other than midwives have been placed in the category of "other." Births attended by naturopahs and others have been included in the category of "out of hospital," but have not been analyzed as a separate group.

White Hospital Births

In 1953, 96.7 per cent of the births to white residents of Florida were attended by physicians, and over 95 per cent were hospital deliveries. While 100 per cent hospital delivery may be considered a desirable goal, the comparatively small number and proportion of white nonhospital births and particularly midwife-attended births cannot be considered a major problem.

Nonwhite Hospital Births

Among the nonwhite population only 56.4 per cent of the infants born in 1953 were delivered in hospitals, and one third were delivered by midwives outside of hospitals. Although the percent-

Prepared by the Bureau of Vital Statistics, Florida State Board of Health, of which Mr. Williams is Director and Mr. Thorner, Chief Statistician.

Table 1. — Number and Per Cent of Resident Births Distributed by Place of Birth and Attendant, Florida, 1953

Place and Attendant	Births			Percentage Distribution		
	All Races	White	Nonwhite	All Races	White	Nonwhite
Total births	80,087	58,262	21,825	100.0	100.0	100.0
Physician in hospital	67,842	55,540	12,302	84.7	95.3	56.4
Physician not in hospital	2,111	787	1,324	2.6	1.4	6.1
Midwife	7,942	660	7,282	9.9	1.1	33.3
Other	2,192	1,275	917	2.8	2.2	4.2

age of hospital births among nonwhites is small when compared with the percentage of white hospital deliveries, it represents a vast improvement over past years. Less than 10 years ago fewer than one fourth of the nonwhite infants were delivered in hospitals. It is probable that the trend toward an increasing proportion of hospital births among nonwhites will continue.

Among nonwhite mothers, the selection of a home delivery by a midwife in preference to a hospital delivery may in many instances be determined by economic considerations. In other instances the lack of hospital facilities for nonwhites, especially in rural areas, may be the determining factor. The influence of custom upon the selection of a midwife delivery should not be minimized. Frequently a combination of the factors mentioned determines the place of delivery and attendant.

Birthweight, Attendant and Place of Delivery

There is a considerable difference in the weight distribution of births occurring in hospitals and the weight distribution of home deliveries. The numbers and per cent distributions by weight, race and place of delivery for the births included in this study are presented in table 2 and figure 1. Median weights in grams are summarized in table 3.

The infants delivered in hospitals as a group average less weight than those delivered at home.

Differences in the weight distributions may be the result of gross errors in the weighing of infants born at home, or may result from processes of patient selection.

Weighing Errors

There is reason to believe that the weighing of infants delivered at home is not as accurate as the weighing of infants in hospitals. The weighing of home-delivered infants is frequently done by midwives who may not make proper allowances for the weight of blankets, et cetera. In other instances the reported weight represents an estimate rather than an actual measurement.

The higher average weights of infants delivered by physicians at home when compared with hospital deliveries suggest that the differences in weight distributions between hospital and nonhospital deliveries may, however, be real and not entirely the result of inaccurate measurement by midwives. Physicians delivered about one fourth of the infants born at home.

Patient Selection

Differences in the weight distributions of infants born in hospitals and those born at home may result from socioeconomic differences be-

Table 2. — Number and Per Cent Distribution of Single Live Births in and out of Hospitals by Race and Weight, Florida, 1953

Weight in Grams	Single Live Births				Per Cent Distribution			
	White		Nonwhite		White		Nonwhite	
	In Hospital	Not in Hospital	In Hospital	Not in Hospital	In Hospital	Not in Hospital	In Hospital	Not in Hospital
Total	55,660	1,534	12,422	8,860	100.00	100.0	100.0	100.0
1000 or less	262	13	96	27	0.5	0.8	0.8	0.3
1001 - 1500	277	11	145	46	0.5	0.7	1.2	0.5
1501 - 2000	622	15	290	91	1.1	1.0	2.3	1.0
2001 - 2500	2,430	61	838	415	4.4	4.0	6.7	4.7
2501 - 3000	9,909	199	2,947	1,473	17.8	13.0	23.7	16.6
3001 - 3500	21,654	448	4,775	2,801	38.9	29.2	38.4	31.6
3501 - 4000	15,544	506	2,559	2,636	27.9	33.0	20.6	29.8
4001 - 4500	4,171	186	640	880	7.5	12.1	5.2	10.0
4501 or more	791	95	132	491	1.4	6.2	1.1	5.5

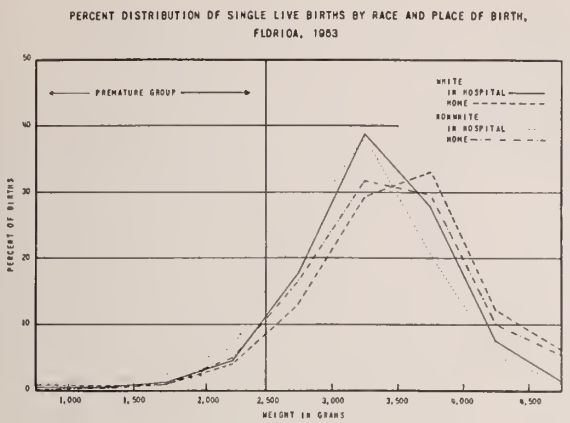


Figure 1

tween the mothers in the two groups. Socioeconomic differences would cause variation between the two groups in the antepartum care received by the mothers, ages of the mothers, and order of the births. These characteristics are known to affect birthweight.[2]

Probably the most important cause of the difference in hospital and nonhospital birthweights is a process of selection which results in the referral of difficult cases to hospitals for delivery.

Midwives in Florida must be licensed and are subject to regulations of the State Board of Health. These regulations require that midwives secure the written permission of the local health department, or of a private physician who has given medical supervision to the patient during pregnancy, before the midwife may deliver a child. This permission must be secured not later than the eighth month of pregnancy.

The midwife must also refer to a reputable physician or to the local health officer any patient having deformities, vaginal bleeding, swelling of the hands and face, or any one of 15 conditions indicative of possible difficulties in delivery.[3]

Under these regulations most patients scheduled for midwife delivery receive an examination by a competent physician, and difficult cases are referred to hospitals.

Table 3. — Median Weights of Single Live-Born Infants by Race, Place of Birth and Attendant, Florida, 1953

Place and Attendant	Median Weight in Grams	
	Race	
	White	Nonwhite
Hospital (physician)	3,332	3,199
Home (all attendants)	3,521	3,426
Physician at home	3,483	3,290
Midwife	3,610	3,465

Prematurity and Attendant

For the reasons indicated, a larger proportion of premature births takes place in hospitals when compared with home deliveries.

The proportions of premature births by race, place of delivery and attendant are presented in table 4.

For both races the smallest proportion of premature births is found among the midwife-attended deliveries, and the largest proportion in the group born in hospitals.

Table 4. — Per Cent of Single Live-Born Infants Weighing 2,500 Grams or Less, by Race, Place of Birth and Attendant, Florida, 1953

Place of Birth	White	Nonwhite
In hospital (physician)	6.5	11.0
Physician not in hospital	6.4	7.6
Midwife	4.7	6.2

Weight Distribution and Neonatal Death Rates

The effect of the uneven distribution of birthweights upon neonatal death rates by attendant is evident from an examination of the crude and weight adjusted rates presented in table 5. Among nonwhites, the crude rates for births attended by midwives indicate a more favorable neonatal mortality experience than for births in hospitals. After adjustment of the rates to the standard weight distribution of all single live births, the survival rates favor hospital births. The lower death rates achieved by midwives (as indicated by the crude rates) appear to result from the selection by midwives of the patients with more favorable prognoses. It is also possible that there is some underreporting of neonatal deaths among midwife-delivered infants. This, too, would tend to lower midwife neonatal death rates. White midwife deliveries are too few in number to permit reliable analysis.

The rates for deliveries at home by physicians appear to be less favorable than the hospital mortality rates, after adjustment for weight differences.

Individual Hospital Rates

A detailed analysis of neonatal death rates in hospitals has been made in connection with this study. In most instances the number of neonatal deaths among births in a particular hospital is too small to permit the computation of reliable weight adjusted rates, and the analysis has been carried

Table 5. — Births, Neonatal Deaths and Crude and Weight Adjusted Neonatal Death Rates, by Race, Place of Birth and Attendant, Florida, 1953

Place and Attendant	White				Nonwhite			
	Births	Deaths	Neonatal Deaths per 1,000 Live Births		Births	Deaths	Neonatal Deaths per 1,000 Live Births	
			Crude	Adjusted			Crude	Adjusted
Hospital (physician)	55,660	922	16.6	18.1	12,422	352	28.3	20.7
Physician not in hospital	926	28	30.2	25.7	1,615	43	26.6	24.7
Midwife	642	5	7.8*	15.2*	7,150	142	19.9	24.1

*Rates subject to extreme variation because of small number of births and deaths.

out in terms of crude rates. Rates by rate size groupings are presented in table 6.

The Bureau of Vital Statistics will make rates for individual hospitals available to hospital administrators, local medical societies and other persons with a proper interest in these figures.

Ranges of Rates

If 300 live births is arbitrarily selected as the rate base necessary for the calculation of reasonably reliable crude neonatal death rates, among hospitals in the study group having over 300 white births in 1953, neonatal white death rates ranged from a low of 8.0 to a high of 44.4 per 1,000 live births. Forty-four hospitals are included in this group. The rate for all hospital births (white) was 16.6 per 1,000 live births (table 6).

There were only 7 hospitals in which 300 or more nonwhite births were recorded in 1953 among the group of hospitals included in the study. The neonatal death rates ranged from a low of 11.6 to a high of 51.1 per 1,000 live births among these hospitals. There were 12 hospitals having 5 or more nonwhite neonatal deaths among live births in 1953 (including hospitals with fewer than 300 births). The nonwhite neonatal mortality rate for all hospital births was 28.3 per 1,000 live births (table 6).

Table 6. — Distribution of Hospital Neonatal Death Rates by Size of Rate and Race, Florida, 1953

Neonatal Deaths per 1,000 Live Births	Number of Hospitals	
	White	Nonwhite
40 and over	1	2
35.0 - 39.9	0	0
30.0 - 34.9	1	1
25.0 - 29.9	1	1
20.0 - 24.9	9	1
15.0 - 19.9	14	0
10.0 - 14.9	11	2
Under 10.0	7	0
Total number of hospitals	44	7
Rate for all hospitals included in the study	16.6	28.3

Note: Includes most hospitals in Florida having over 300 births in 1953.

Comparison with National Rates

In the study conducted by Shapiro and Unger[3] using national data for early 1950, the neonatal death rate among hospital births for singly born white infants was 16.7 per 1,000 live births compared with 16.6 for the white hospital births included in this study. Among nonwhite hospital births the national figure for 1950 was 25.1 compared with a nonwhite rate of 28.3 for the Florida group. The national figures apply to 1950, and it is probable that 1953 figures, if available, would be lower.

Meaning of the Rates

Of the 1,499 neonatal deaths included in this (the Florida) study, 1,274 or 85 per cent occurred among infants born in hospitals. If further substantial reductions in neonatal mortality are to be achieved, it is obvious that the reduction must take place among hospital births.

A high neonatal death rate for a particular hospital may or may not be an index of the quality of medical care received by mothers and infants in that hospital. Obviously, the rate may be considerably influenced by the socioeconomic status of the patients admitted to the hospital. County-operated hospitals and hospitals with a large proportion of charity cases tend to have a larger proportion of mothers who have poor nutritional levels and recent histories of chronic and acute illnesses, and who have received little or no antepartum care.

The hospital neonatal death rate does, however, pinpoint the hospitals and groups of patients which require further study. The studies should be planned to ask and answer such questions as: Is the antepartum care received by the patients of this hospital adequate? Is the quality of medical care received adequate? Does the equipment of the hospital meet the minimum requirements

for the proper care of the newborn, especially the premature? Is the staff properly trained and supervised in the handling of newborn infants? When answers have been obtained to these questions, remedial action may be properly planned. Analysis of individual cases and causes of death also should prove of value. Studies of this type properly belong within the activities of individual hospitals and the local medical societies. Hospitals with rates in excess of the state rate for all hospitals should be subjected to study.

Summary and Conclusions

While the proportion of hospital births among nonwhites remains small, the trend in recent years has been encouragingly upward, and further increases may be anticipated.

The infants born at home were a heavier group than those delivered in hospitals. This may be the result of measurement errors in home deliveries or may result from patient selection.

Although crude neonatal death rates for midwife deliveries are lower than hospital rates, the hospital rates appear more favorable after adjustment for weight distribution differences between the two groups. The lower midwife rates apparently result from patient selection and possibly from the underreporting of neonatal deaths among midwife deliveries.

Regardless of differences in neonatal death rates between hospital and midwife deliveries, 85 per cent of the neonatal deaths occurred among hospital births, and the problem is concentrated chiefly in this group.

Rates among hospitals exhibit considerable variation. The differences may be indicative of the quality of hospital care, or may result from patient selection processes.

Neonatal death rates per 1,000 single live births among white infants delivered in Florida hospitals in 1953 were about the same as national rates for 1950 (Florida 16.6, United States 16.7). Nonwhite rates were higher (Florida 28.3, United States 25.1).

Studies of hospitals with excessive neonatal rates should provide a sound basis for the institution of remedial action. Such studies are within the province of the individual hospital and the local medical societies.

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Box 210.



ABSTRACTS

Congenital Glaucoma: Cyclodiathermy and other Surgical Therapy. By Sherman B. Forbes, M.D. South. M. J. 48:954-964 (Sept.) 1955.

The surgical management, technic employed, and prognosis in the treatment of congenital glaucoma are described in this paper, and the results in a series of cases are reported. The value of cyclodiathermy in the treatment of this disease is discussed, and its role in combination with goniotomy is evaluated. The belief is expressed that cyclodiathermy alone frequently will control the disease and that in certain cases goniotomy, by facilitating aqueous outflow, and cyclodiathermy by decreasing aqueous production, when combined, provide an excellent means of obtaining the surgical objective of controlling the intraocular pressure.

The technic of the operation by the newer method, which includes placing the penetrating punctures a greater distance from the limbus than formerly, is described.

A series of 6 cases is reported in which cyclodiathermy was used effectively. In 2 of these cases this therapy was combined with goniotomy. There were 2 cases of simple congenital glaucoma, 2 with associated nevus flammens, and 2 with associated microphthalmia. In addition, 3 of 6 cases previously reported are reviewed and brought up to date, and 3 more cases, treated in a similar manner with satisfactory results after the paper was submitted for publication, are mentioned in an addendum.

It is concluded that cyclodiathermy, as performed by the newer technic, is a safe and frequently effectual procedure in the treatment of congenital glaucoma.

Surgical Injuries to the Lower Segment of the Ureters and Bladder: Use of the Diverticulite in Ureteral Repair. By Milton M. Coplan, Frank M. Woods and Perry D. Melvin. Tr., Southeastern Sect. Am. Urol. A., 1954.

With the advent in recent years of more extensive and more radical surgery of the pelvic organs, the incidence of injury to the lower segment of the ureters and to the urinary bladder has occurred too frequently. This observation led the authors to make a critical analysis of a series of 25 cases of this type encountered in their practice, in 8 of which there were bladder injuries and in 2 a urethral injury with urethrovaginal fistula. Of the bladder cases, 1 was a partial resection unrecognized until the tissue was removed with the tumor; 7 were vesicovaginal fistulas that developed two to three weeks after pelvic surgery. They present in this article the results of their study with a two-fold purpose: first, to further the campaign directed toward preventing injuries to the urinary tract when pelvic surgery is performed and, second, to contribute an operative technic which, in their experience, has lessened the difficulty of identifying and liberating the distal end of the ureter when surgical repair of an injured ureter becomes necessary.

In summary, they conclude that injury to the urinary tract, one of the most fearful complications of pelvic surgery, usually can be prevented by preoperative urograms and by indwelling ureteral and bladder catheters during the surgery. Also, injury recognized at surgery can be repaired or temporarily cared for by diverting the urine through a tube extraperitoneally, allowing definitive care at a later date. A great number of normal repairs, they add, can be effected with the aid of a cystoscopist using a uretheral transilluminator (diverticulite) or large catheter in the ureter while the surgeon is making the repair. They report that vesicovaginal repair is greatly facilitated by use of the Foley catheter to support and immobilize the floor of the bladder.

Treatment of Herpes Zoster with Gamma Globulin. By I. Irving Weintraub, M.D. J. A. M. A. 157:1611 (April 30) 1955.

The author used gamma globulin to treat 6 patients, 3 men and 3 women, ranging in age from 20 to 60 years. Five of these patients had the classic symptoms of herpes zoster, systemic manifestations, radicular pain, and herpetic skin lesions; the sixth patient had typical postherpetic neuralgia of two years' duration.

Four patients experienced dramatic relief of pain within the first 24 hours. In no case was there further progression of the skin lesions after the first injection, and there was no evidence of any secondary infection. The patient with lesions

of seven days' duration experienced relief within 48 hours after the first treatment. The one whose disease had lasted for 12 days had hemorrhagic skin lesions; with injection of the gamma globulin the lesions just forming disappeared completely without scarring and those already hemorrhagic receded rapidly without any gangrene or ulcer formation. In all cases, the inflamed, reddened halo on the vesicles disappeared after the first injection. Complete healing of the skin lesions progressed in the usual manner, requiring one to three weeks. The rate of healing of the superficial lesions seemed to vary with their duration prior to the first injection of gamma globulin. In the single case of postherpetic neuralgia, the patient showed no improvement. No complications or sequelae were observed in the other 5 cases. All of the patients except the one with hemorrhagic skin lesions, who was hospitalized, continued their work in the usual manner, in spite of extensive involvement in some cases.

Accident Prevention in Childhood — The Kerosene Hazard. By Hugh A. Carithers, M.D. J. A. M. A. 159:109-111 (Sept. 10) 1955.

The role of accidents as a cause of death in young children is here discussed. In 1951 1952 in the 1 to 4 year age group accidents were in first place, almost doubling in number the deaths from pneumonia and influenza, the next ranking group. In addition, it has been estimated that for every fatal accident among children there are at least 100 nonfatal accidents, 4 of which result in some permanent disability. The percentage distribution, by principal types, of deaths from accidents among children 1 to 4 years of age in 1951-1952 is presented, and while poisonings is preceded by motor vehicles, burns, drowning, and falls in the list, this cause nevertheless gives rise to an important aspect of the problem and illustrates its magnitude. Poisonings are most likely to occur in children of ages 1 through 2, the age of inquisitiveness when some children will eat or drink almost anything.

Kerosene poisoning is discussed in some detail, and a study of poisonings among children in Florida caused by ingestion of volatile oils is reported. A survey showed that over 500 Florida children were treated in one year for volatile oil poisoning, caused in nearly all cases by ingestion of kerosene. A detailed study of all cases of poisoning from petroleum oil products at the Duval Medical Center in Jacksonville was evaluated in terms of length of hospitalization and per diem cost of patient care. In this area where kerosene is widely used for heating as well as cooking, it was noteworthy that the distribution of the cases was fairly equal, the surprising number in summer emphasizing the important principle of giving active youngsters fluids between meals, especially in hot weather, so that thirst will not be the stimulus to the consumption of liquid poison. The causes of death from kerosene poisoning are discussed and also the problem of treatment.

Specific suggestions of proved value in accident prevention which physicians can make a part of their routine practice are presented.

The Surgical Treatment of Mitral Stenosis. By W. C. Sealy, M.D., John P. Collins, M.D., and Richard G. Connar, M.D. North Carolina M. J. 15:202-205 (May) 1954.

A series of 34 cases of mitral stenosis is reported in which the patients were treated surgically by the staff at Duke Hospital, Durham, N. C. There were 13 men and 21 women, whose ages varied from 22 to 56 years. Once entry into the heart chambers was gained by introduction of the finger into the auricle, the valve was divided either with a special knife or with finger manipulation. The experiences with these patients are summarized and the results tabulated. The results of valvulotomy were excellent in 14 cases, good in 13, improved in 4 and worse in 1, with 2 deaths. Complications were cerebral embolus in 2 cases, postoperative pericarditis in 8, operative death in 1 and death from acute rheumatic fever in 1. It is concluded that the surgical correction of mitral stenosis is a rational procedure which is now indicated whenever it is the cause of disabling symptoms. No patient with a symptomatic tight mitral stenosis should be denied the benefit of this procedure in the opinion of these authors.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 1018, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

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Status of Social Security Legislation

As the one hundred and first and the final witness testifying before the Senate Finance Committee on H.R.7225, the Social Security bill, Marion B. Folsom, Secretary of the Department of Health, Education, and Welfare, on March 22 made his position and that of the Eisenhower administration altogether clear. The administration approves extension of coverage, but opposes reduction of retirement age for women and payments for disability. Mr. Folsom expressed firm opposition to these two major provisions of the House-approved Social Security amendments: cash payments to disabled workers at age 50, and the lowering of retirement age for women from 65 to 62. For three full hours he made a masterful presentation, advancing arguments not based on political considerations, but on logic and common sense. He noted that many of the same arguments had been made earlier before the Committee by physicians and other witnesses. His answers, in the opinion of one medical leader, "proved beyond question that Mr. Eisenhower picked a big man for a big job — a man intellectually equipped to handle a hot, controversial issue in a right smart manner."

The American Medical Association has stated its firm opposition to disability payments under social security because: (1) permanent and total disability is difficult to determine; (2) a finding of permanent and total disability would, in many cases, kill the incentive to be rehabilitated; (3) physicians would be under pressure from both their patients and government in reaching a professional opinion as to disability; and (4) the admittedly high cost cannot be estimated with any accuracy. The American Academy of General Practice, meeting recently in scientific assembly at Washington, also registered opposition to the disability section of the bill because: "(1) H.R.7225 falsely assumes that disability determination is an exact science when actually such determination hinges on nature and extent of causative factors, on a doctor's diagnostic skill and on the willingness of the patient to be rehabilitated, (2) testimony developed at the recent Senate hearings indicates the annual cost of the disability program if extended to workers of all ages could exceed $2 billion annually."

Although Mr. Folsom, as a spokesman for the administration, greatly improved the doctors' position by his strong opposition to cash disability, physicians by no means have won their fight against H.R. 7225. Two days after Mr. Folsom gave his testimony, Adlai Stevenson expressed just

the opposite view in a statement to the press saying, "The changes, approved by the House last year, 372 to 31, are good ones and clearly in the general interest." It is to be remembered that the House Ways and Means Committee, without holding public hearing and over the protest of the American Medical Association and others, reported out this bill in 1955. The House then passed it, 372 to 31, under gag procedure denying adequate debate or floor amendment. Obviously, the pressure for cash disability benefits will not cease this year until the final adjournment of the Congress.

In contrast to House procedure, the Senate Finance Committee under Chairman Byrd conducted public hearings from January 25 through March 22. Mr. Folsom said the American people "owe a large debt" to the Committee for its decision to conduct extensive hearings. A preponderance of the 101 witnesses opposed disability payments. Among these was Dr. H. Phillip Hampton, of Tampa, Chairman of the Committee on Legislation and Public Policy, who spoke on behalf of the Florida Medical Association. The Committee in executive sessions now will have to pass on more than 30 amendments, including Senator George's proposal for disability payments at any age and Senator Kerr's amendment to add a food stamp plan on top of payments to public assistance recipients. Then the Committee will have to decide whether to report out the bill in any form, or if it is to be reported out, whether to delete the disability payments and some other sections. Executive consideration has been delayed repeatedly, but once that is over, H.R. 7225 may go to the Senate floor promptly, as Majority Leader Lyndon Johnson has given it priority. At this writing work on the bill behind closed doors is just beginning.

National Medical Library Bill

Legislation before the Congress to set up the Armed Forces Medical Library in a new building with a new name and under a new government agency should interest physicians generally. Senator Hill of Alabama, with Senator Kennedy of Massachusetts as co-sponsor, in March introduced a bill (S. 3430) taking this famous library from under the Defense Department and making it a separate entity with the name of National Library of Medicine. They left open the question of whether to place it under the Smithsonian Institution as recommended by the Hoover Commission or some other agency such as the Department of Health, Education, and Welfare. Senator Hill pointed out that the present library, with its wealth of material, provides considerable information for civilian medical science, and Senator Kennedy stressed that the library cannot compete for funds in the Defense Department against the needs and demands of national defense.

The bill was referred to the Senate Labor and Public Welfare Committee, which had no immediate plans for hearings, but by mid-April at a two day Senate session nearly a score of witnesses gave full support to it. There was division of opinion on whether to give it independent status or place it under some federal agency. Strongest sentiment, however, developed for placing it in the Department of Health, Education, and Welfare.

The American Medical Association's House of Delegates in June 1954 urged a new building for the present library and called on the government to give it "immediate priority." At the hearing in April of this year the American Medical Association went on record as favoring immediate construction of new quarters under the Department of Health, Education, and Welfare. Dr. Preston A. McLendon, of Washington, testified that if properly supported, the library will continue to be of "inestimable value to medical education and medical research."

Dr. Frank Berry, Assistant Secretary of Defense, announced Defense support of the bill. The support of the Department of Health, Education, and Welfare was pledged by Dr. Lowell Coggeshall, a special assistant, in case the Congress votes to set up the library in that agency. Surgeon General Leonard Scheele of the Public Health Service even outlined details of how it could be set up in that service. He suggested, for instance, that in place of an outside board of regents, a national advisory board be formed with the Surgeon General of the Public Health Service as chairman. Among others favoring the bill were representatives of the Rockefeller Foundation, Baylor University School of Medicine, Harvard Medical School, the American College of Surgeons, the Association of American Medical Colleges and the Society of Medical Consultants to the Armed Forces.

If the bill continues to move along and is passed, there still is time to amend the appropriation for the Department of Health, Education,

and Welfare and avoid delay on construction. The need for new quarters suitably located certainly is obvious to any physician who has visited the present library for study. This great institution adequately housed as the National Library of Medicine would reflect great credit on the nation and the medical profession.

Chronic Illness Care a New Frontier

Today's increasing longevity, the gift of modern medical, social and industrial sciences, brings in its wake medical and social problems of such magnitude as to make chronic illness the leading health problem of the midcentury. As people grow older, they fall prey to the many chronic diseases and other ills of the aged. Caring adequately and economically for patients with such ills on a long term basis is posing problems this country is finding itself ill prepared to meet. It is faced with a new frontier and a new challenge.

According to a reliable estimate, more than 2,000,000 persons in the United States suffer from chronic illness so serious that they require long term care. This number does not include mentally ill patients or those with tuberculosis. From one half to two thirds of the chronically ill receive care at home. The remainder, some 750,000, need care in some type of institutional facility. To meet current needs for long term care, it is roughly estimated that there should be about 5 beds per 1,000 population in units attached to general hospitals, infirmaries, homes for the aged, and nursing homes.[1]

The changing disease pattern doubtless is chiefly responsible for the increasing demand for long term care. Advances in medicine and public health services have changed the types of disease which predominate as causes of illness and the ages at which illness and death most frequently occur. Half a century ago, the major proportion of all illness and deaths occurred in early life, struck suddenly, caused immediate severe illness, and terminated rapidly. Among the diseases were diphtheria, smallpox, typhoid fever, dysentery, pneumonia, and other acute infectious diseases. Now greatly reduced, these diseases have been superceded by diseases of the heart, arteriosclerosis, arthritis, cancer, diabetes, nephritis, and other long term diseases. At the present time, chronic diseases are responsible for the major part of all illness and for about 80 per cent of all deaths.[1] Occurring predominantly among persons in the middle and later years of life, they begin slowly, progress gradually, and terminate only after months or years of slowly increasing disability. Even the mortality figures do not indicate the full extent of the increase in the prevalence of long term disabling illness for death often is caused by intercurrent disorders.

Other contributing causes are shifts in family composition and living arrangements which have decreased the ability of families to care for patients in their own homes. Not only are there more middle-aged and elderly people in the population, but the size of the family has decreased, there are many childless marriages, and the number of single people increases. Too, the growth of insurance and pension plans has changed the methods of providing support and care for older people, and rising living standards have made the luxuries of yesteryear necessities today.

The trend is upward. The widespread need for long term care of the chronically ill and infirm is the result of alterations in medical, social and economic factors not likely to be reversed, and the demand will only increase in the foreseeable future. Further improvements in medicine and related health services offer the one hope of stemming the rising tide.

It is extremely important, therefore, that an orderly, sound and coordinated approach be made now on this new frontier. Growing public interest in the problem must not be allowed to forge ahead of the knowledge on which to base appropriate action. A distinguished banker, who is chairman of the National Committee on the Aging, makes this pertinent comment in his foreword to a new book, entitled "Planning New Institutional Facilities for Long Term Care:"[1]

"I believe there is no greater fear than that of being old and sick and without income from work or pension, and without proper care. Few people, however, realize the magnitude of the financial resources necessary to provide adequate pensions and adequate care. Nor do they generally realize that although obviously we must provide the necessary financial stability and care, because of the great cost it must be accomplished through an educated and informed approach so as not to dislocate our economic balance. For example — if all of the more than 60 million employees in the country were to receive privately financed pensions at no more than current levels, and the benefits were fully funded on an actuarily

sound basis, the total funds required would exceed in value all of the stocks listed on the New York Stock Exchange."

Obviously, the long look is essential to wise planning in meeting an ever increasing demand for long term care. All who are facing up to the problem in communities throughout the land will find in the book mentioned a wealth of ideas, information, and experience compiled in an exhaustive 10 year study. Now is the crucial period in the development of facilities for this type of care. The challenge is compelling, but interest and demand for action must not be allowed to become a hazard by dangerously outstripping sound knowledge and analytical thinking about what should be done and how it can be accomplished.

1. Nicholson, Edna: Planning New Institutional Facilities For Long Term Care, New York, G. P. Putnam's Sons, 1956.

First Pan American Cancer Cytology Congress: Invitation to Program Participation Miami, April 25-29, 1957

Physicians wishing to present scientific papers at the forthcoming First Pan American Cancer Cytology Congress, to be held in Miami April 25-29, 1957, are requested to communicate with Dr. M. J. Kopac, Program Chairman, Washington Square College of Arts and Sciences, New York University, New York City, or Dr. Wayne S. Rogers, 1155 N.W. Fourteenth St., Miami. The program of the Congress will be devoted to recent advances in cancer cytology in early cancer diagnosis and research, applications of basic cytology in fundamental research and related fields of cancer research including radioactive isotopes and leukemia. It will include the presentation of leading scientific papers by invited guest speakers. Other participants wishing to present papers should submit the title of their paper with a 100 word summary. Preference will be given to early applicants.

Two awards of $1,000 each will be presented at the conclusion of the Congress to the two scientists presenting papers whose work is judged to represent "outstanding research in cancer cytology." These awards, called the Wien Award, are presented annually to recognize and encourage further research in cancer cytology. Established in 1953 by Leonard Wien, former president of the Cancer Institute at Miami, the Award consists of a plaque suitably inscribed and $1,000 to be given each year to the work judged by a research committee headed by Dr. E. V. Cowdry, as representing the most significant research in cytology in that year. Awards for 1956 and 1957 are to be made at the Congress. Previous recipients of the Wien Award include Dr. George N. Papanicolaou and Dr. J. Ernest Ayre. For further information about the Congress write to Mrs. Elizabeth Maselli, P. O. Box 633, Miami 34.

Mount Sinai Hospital Annual Postgraduate Seminar Held in Miami Beach

The Mount Sinai Hospital of Greater Miami presented its Sixth Annual Postgraduate Seminar last month at the Fontainebleau Hotel in Miami Beach. It opened on May 17, the day after the state convention of the Florida Medical Association ended at the same hotel, and continued through May 20. A distinguished faculty presented a wide variety of subjects on the general theme of "Recent Advances in Diagnosis and Therapy."

Among the eminent lecturers were: Dr. Alexander Brunschwig, Professor of Clinical Surgery, Cornell University Medical College; Dr. Joseph J. Bunim, Clinical Director, National Institute of Arthritis and Metabolic Diseases; Dr. George Crile Jr., Cleveland Clinic Foundation; Dr. Robert B. Greenblatt, Professor of Endocrinology, Medical College of Georgia; Dr. Maurice Greenhill, Professor of Psychiatry and Neurology, University of Miami; Dr. Keith S. Grimson, Professor of Surgery, Duke University; Dr. Ralph Jones Jr., Chairman of the Department of Medicine, University of Miami; Dr. Louis Leiter, Clinical Professor of Medicine, Columbia University; Dr. William F. Rienhoff Jr., Associate Professor of Surgery, Johns Hopkins University; Dr. Hans Selye, Director of the Institute of Experimental Medicine and Surgery, University of Montreal; Dr. Solomon Silver, Assistant Clinical Professor of Medicine, Columbia University; and Dr. Edward Weiss, Professor of Clinical Medicine, Temple University.

In addition to the lectures, a symposium was a daily feature of the Seminar. The first one was on "Stress," with Dr. Selye one of the participants. The subjects of the other two were "Diseases of Disturbed Metabolism" and "Modern Concepts of Treatment of Carcinoma: Radical Versus Conservative Approach."

The chairman of the local committee on arrangements was Dr. Harold Rand.

New American Medical Directory Shows Great Florida Gain

Twenty months of work have culminated in completion of the nineteenth edition of the American Medical Directory. The shipping late last month of the first copies of this first edition since 1950 is welcome news. It was originally scheduled for publication in 1952, but postponement became necessary because the changeover during that period to a dues-paying membership structure in the American Medical Association made it impossible to obtain an accurate list of members. Late in 1954, work began on the new edition with the sending of information cards. "It was only with the cooperation of the medical profession and allied organizations," said Editor Philip E. Mohr of the A. M. A. Directory Department, "that it was possible to bring the Directory up to date and produce a book of this scope."

The 3,122 pages of this new edition contain information on 240,638 physicians in the United States, its dependencies, and Canada. Also listed are American graduates temporarily located in foreign countries. Since the 1950 Directory was published, more than 250,000 changes of address have been recorded in the files of the Directory-Biographical Department, 46,348 names have been added, and 24,225 have been deleted because of death, with an additional 1,172 deleted for other reasons.

Florida now has 4,530 physicians as compared with 3,025 in 1950. This increase of 1,505 physicians in six years represents a gain of 49.8 per cent. California leads in the number gained, with 20,763 physicians in 1956 as compared with 16,668 in 1950, a gain of 4,095 or 24.6 per cent. Texas shows a gain of 1,026 physicians; Ohio, 990; Michigan, 963; and New York, 934. Among the smaller states showing a substantial increase in the number of physicians are Arizona, New Mexico, Oregon, and Utah, while Arkansas, Illinois, Iowa, Missouri, Vermont, and West Virginia show slight losses.

By areas, the Pacific States, as in 1950, show the largest increase in physicians for 1956, with a gain of 23 per cent over the 1950 figures; the South Atlantic and Mountain States show gains of about 16 per cent, and the Central, Middle Atlantic and New England States show small gains. In the 1950 Directory, the total number of physicians listed in the United States was 201,277; in the 1956 edition, the number is 218,061, a gain of 16,784, or an average yearly gain for the past six years of 2,797.

Included in the statistical information in the 1956 Directory is a table showing the number of physicians by states classified as to type of practice. The figures given indicate that 30 per cent of the physicians in the United States are in general practice; 10 per cent give special attention to a specialty but do not limit their practice to it; 31 per cent limit their practice to a specialty; 11 per cent are serving internships or residencies, with an additional 6 per cent in other full time hospital services; 5 per cent are retired or not in practice; 4 per cent are not in private practice; and 3 per cent are temporarily in military service or serving in various government agencies.

Another table shows the distribution by states of specialists in the United States, with a breakdown of those interested in a specialty, those limiting their practice, and those certified as specialists by examining boards in a medical specialty.

Florida's phenomenal increase in physician population in the short span of six years is in keeping with the state's rapidly increasing general population and the remarkable way in which the whole state is forging ahead.

Public Warned Against Hoxsey Cancer Treatment

An unusual "public warning," issued by the Food and Drug Administration in April, cautions "sufferers from cancer, their families, physicians, and all concerned with the care of cancer patients" to avoid the Hoxsey treatment. This announcement, like all earlier warnings from this source, pertains to dangerous drugs, but this is the first time in recent years such a warning to the public has been issued.

In this notice the Food and Drug Administration informs the public that the treatment, developed by Harry M. Hoxsey of Texas, was found "worthless" by the United States Court of Appeals, that it represents "gross deception" and that relying on it in neglect of competent treatment is "imminently dangerous." The Court decision was reviewed editorially in the November 1952 issue of The Journal.

The public warning says in part:

"The Hoxsey treatment costs the patient $400 plus $60 in additional fees; expenditures which will yield nothing of any value in the care of cancer. It begins with a superficial and inadequate examination of the patient at the Hoxsey Cancer Clinic, Dallas, Texas, or Portage, Pennsylvania.

The patient at Dallas is then supplied with one of the following 'cancer' medicines: Black pills, red pills, a brownish-black liquid, or a light red liquid. The black pills and the brownish-black liquid contain: Potassium iodide, licorice, red clover blossoms, burdock root, Stillingia root, berberis root, poke root, cascara sagrada, prickly ash bark, and buckthorn powder. The red pills contain potassium iodide, red clover, Stillingia root, poke root, buckthorn, and pepsin. At Portage the patient is given the same 'cancer' medication although the colors of the pills are different. The light red liquid medicine is potassium iodide in elixir of lactated pepsin. There is evidence that potassium iodide accelerates the growth of some cancers.

"The Food and Drug Administration has conducted a thorough and long-continuing investigation of Hoxsey's treatment. His claimed cures have been extensively studied and the Food and Drug Administration has not found a single verified cure of internal cancer effected by the Hoxsey treatment. In addition, the National Cancer Institute of the United States Public Health Service has reviewed case histories submitted by Hoxsey and advised him that the cases provided no scientific evidence that the Hoxsey treatment has any value in the treatment of internal cancer."

Commissioner George P. Larrick of the Food and Drug Administration, who issued the warning, did so "for the immediate protection of cancer victims who may be planning to take the Hoxsey treatment." He pointed out that Harry M. Hoxsey and "all persons in active concert with him" in the treatments were enjoined on Oct. 26, 1953, from shipping their "worthless cancer medicines" in interstate commerce with labeling representing, suggesting, or implying that the products are effective in the treatment of any type of internal cancer.

While the government intends to prosecute violations of the injunction, the timely warning urges now that persons afflicted with cancer not be misled by the false promise that the Hoxsey cancer treatment will cure or alleviate their condition. It explains that cancer can be cured only through surgery or radiation and stresses that "death from cancer is inevitable when cancer patients fail to obtain proper medical treatment because of the lure of a painless cure 'without the use of surgery, x-ray, or radium' as claimed by Hoxsey."

Graduate Medical Education

Short Course
June 25-29, 1956

The program for the Seminar on Gastroenterology and for the Twenty-Fourth Annual Graduate Short Course appeared in detail in the May issue of The Journal. The Short Course will be held the week of June 25-29 at the George Washington Hotel in Jacksonville. Dr. James V. Warren, Professor of Medicine, Duke University School of Medicine, will deliver the lectures on Medicine. Dr. Warren is well known to many physicians in Florida. He takes the place of Dr. Samuel P. Martin, the newly appointed Professor of Medicine of the College of Medicine of the University of Florida, who was to have presented these lectures. Because of conflicting dates which make it necessary for Dr. Martin to appear that week before the State Board of Medical Examiners for examinations, he was obliged to cancel the Short Course engagement.

This year, as last, there will be two panels, one on Medicine coming Tuesday afternoon and one on Surgery on Friday afternoon. In addition, particular attention is directed to an evening panel discussion on "Eye Emergencies" which will be held at 8 p.m. on Tuesday, June 26. This panel will be open to all physicians whether registered for the Short Course or not. The Florida Council for the Blind is sponsoring this panel, and the ophthalmologists of Florida are cooperating. Dr. Shaler Richardson, of Jacksonville, will be the moderator, and members of the panel will be Dr. Nathan S. Rubin, of Pensacola, Dr. Carl S. McLemore, of Orlando, and Dr. Sherman B. Forbes, of Tampa.

Advance registration will be appreciated for the Seminar on Gastroenterology, scheduled for June 21-23, immediately preceding the Short Course, and held also at the George Washington Hotel in Jacksonville. Hotel reservations may be secured in advance by addressing the Division of Postgraduate Education, 1625 Riverside Avenue, Jacksonville 4.

American Medical Association Annual Meeting in Chicago

The 105th Annual Meeting of the American Medical Association is being held in Chicago June 11-15. Plans are complete for five days of lectures, exhibits, color television and motion pictures. Activities will be centered at Navy Pier and the Palmer House will be headquarters for the House of Delegates.

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BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Joseph Coudon of Jacksonville announce the birth of a son, George Price Whitaker, on February 1, 1956.

Dr. and Mrs. Robert J. Andrews of North Miami Beach announce the birth of a daughter, Judy Ann, on March 5, 1956.

Marriages

Dr. Charles F. Biggane of Miami and Miss Jacqueline Frohock were married February 18, 1956, at Miami.

Deaths - Members

Bartlett, Chas. W., Tampa	March 1, 1956
Cleverdon, Lawrence A., Stillwater, Okla.	January 10, 1956
Golinvaux, C. J., Surfside	February 14, 1956
Henderson, Robert P., Orlando	March 22, 1956
Humphreys, David G., Fernandina Beach	March 16, 1956
Jenkins, Valentine E., Miami Beach	March 30, 1956
Lancaster, Blake M., Manatee	March 26, 1956
Mitchell, George M., Jacksonville	March 31, 1956
Nichols, William S., Lake City	March 28, 1956

Deaths - Other Doctors

Nichols, John A., Miami Beach	March 25, 1956

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Bachnik, Francis W., St. Petersburg
Boyd, Thompson H., Miami
Broward, John A., Miami
Cason, James F., Panama City
Catanzaro, Charles, Tampa
Cole, Lee M. Jr., Miami
Collins, Harry L., Jacksonville
Couture, Walter H., St. Petersburg
Dowswell, John W., St. Petersburg
Frazier, Donald B., Jacksonville
Freeman, Joseph, Miami
Galluccio, Joseph R., Miami
Gilbert, Michael M., Miami
Greiwe, Thomas, Tampa
Harlow, Joseph E., Tampa
Heibner, Winston C., St. Petersburg
Howard, H. Carlton, Miami
Howard, Paul E., Miami
Krauss, Maurice D., Miami Beach
Laffitte, L. Sydnor, Jacksonville
Leslie, Samuel P., Miami Beach
Linton, Lillie O., Tallahassee
McKenna, John F., South Miami
Monyek, Milton S., North Miami Beach
Murphy, George M., Indianapolis, Ind.
Patterson, Lawrence G., Largo

Rubio, Mauricio, Tampa
Scott, Thomas E. Jr., Daytona Beach
Smith, James E., Jacksonville
Stein, Benjamin F., Sarasota
Stinger, Naomi T., Tallahassee
Stinger, William T., Tallahassee
Swords, Collins W. Jr., Miami
Trope, Robert J., Miami Beach
Turnage, Johnson L., Crestview
Uzmann, John W., Jacksonville
Ward, Harold W., Tallahassee
Webb, John H. Jr., Orlando
Witkind, Elliott, Miami

COMPONENT SOCIETY NOTES

Dade

"Tax Deferment for Professional Men" was the subject of the panel discussion featured at the April meeting of the Dade County Medical Association. Panel members were Mr. Willard R. Brown, vice president and trust officer, First National Bank of Miami; Mr. Atwood Dunwody, attorney, and Mrs. Beth Thompson, certified public accountant.

Hillsborough

Dr. Edward L. Jenkinson, of Chicago, was guest speaker at the April meeting of the Hillsborough County Medical Association. The title of his address was "Treatment of Carcinoma of the Larynx." Dr. Jenkinson is Professor of Radiology and Director of the Department of Radiology at Northwestern University School of Medicine, Chicago, and also Director of the Department of Radiology at St. Luke's Hospital in Chicago.

Orange

Dr. James R. Cook, of Orlando, was principal speaker at the April meeting of the Orange County Medical Society. The title of his address was "Treatment of Nodular Goiter with Radioactive Iodine."

At the May meeting, Dr. Benjamin M. Cole, of Orlando, appeared as principal speaker discussing the subject "The Orange County General Practitioner."

Pinellas

Dr. James L. Gouaux, of St. Petersburg, was principal scientific speaker for the May meeting of the Pinellas County Medical Society. The title of his address was "Heart Sounds and Murmurs." Another part of the program was "Mountains of Europe and U.S.A.", a series of colored slides shown by Dr. H. Milton Rogers, also of St. Petersburg.

Duval

A panel discussion on the subject "Recent Advances in Anesthesia" was the feature of the May meeting of the Duval County Medical Society. Serving on the panel were Drs. James D. Beeson; Dominic A. Bianchi; Wayland T. Coppedge; Leo F. Klenk; James E. Smith; John T. Stage, and John W. Uzmann.

STATE NEWS ITEMS

Dr. James N. Patterson of Tampa has returned from Cincinnati where he attended the meetings of the American Association of Pathologists and Bacteriologists and the International Association of Medical Museums. Before going to Cincinnati, Dr. Patterson spent a few days in Boston at The Harvard Medical School where he was one of the officials administering examinations of the American Board of Pathology.

The Fourth International Congress on Diseases of the Chest of the American College of Chest Physicians will be held in Cologne, Germany, August 19-23, under the patronage of the Federal Chancellor Dr. Konrad Adenauer. The first Congress after the war was held in Rome in 1950, the second in Rio de Janeiro in 1952 and the third in Barcelona in 1954. Eighty-six countries will send representatives. The German Committee of the Congress invites all members of the American College of Chest Physicians, as well as all other medical societies and specialists who are interested in problems of diseases of the chest, to attend.

Dr. Alvan G. Foraker of Jacksonville attended the recent meetings of the International Academy of Pathology and the American Association of Pathologists and Bacteriologists held in Cincinnati. He presented a paper before the latter group entitled "The Occurrence of Glycogen in Squamous Cell Carcinoma of the Uterine Cervix."

Dr. Peter J. Spoto of Tarpon Springs has been appointed clinical director of Anclote Manor located in the same city.

Dr. Louis M. Orr of Orlando was annual orator for the Seventy-Sixth Annual Meeting of the Louisiana State Medical Society held the latter part of April in the Hotel Bentley at Alexandria. The title of Dr. Orr's address was "To Socialized

(Continued on Page 1034)

ACHROMYCIN*

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The prevention and control of cellulitis, abscess formation, and generalized sepsis has become commonplace technique in surgery since ACHROMYCIN has been available. Leading investigators have documented such findings in the literature.

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[1]Albertson, H.A. and Trout, H. H., Jr.: *Antibiotics Annual* 1954-55, Medical Encyclopedia, Inc., New York, N.Y., 1955, pp. 599-602.

[2]Prigot, A.; Whitaker, J. C.; Shidlovsky, B. A., and Marmell, M.: *ibid*, pp. 603-607.

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ACHROMYCIN ACHROMYCIN [redacted]

(Continued from Page 1031)

Medicine by Way of the Veterans Administration."

Dr. Sidney Smith of Bradenton was guest speaker at a recent meeting of the Rotary Club of that city. Heart disease was the subject of his address.

Dr. Henry L. Harrell of Ocala has returned from Washington, D. C., where he attended the annual meeting of the American Academy of General Practice.

Dr. Charles K. Donegan of St. Petersburg discussed cardiology at a recent meeting of the Largo Rotary Club.

Dr. Edward R. Annis of Miami was principal speaker at a recent meeting of the Coral Gables Pilot Club. The title of his address was "Government Is Your Business."

Dr. Thomas F. McDaniel of Sanford attended the Eighth Annual Scientific Assembly of the American Academy of General Practice held at Washington, D. C.

Dr. Grayson C. Snyder of Blountstown has been appointed chairman of the American Cancer Society's 1956 educational and fund raising crusade in Calhoun county.

Dr. George D. Hopkins II of Fort Myers has been elected president of the Lee County Tuberculosis and Health Association. Drs. Merwin E. Buckwald and John S. Stewart have been named to the Advisory Committee. Both are from Fort Myers.

Dr. Spencer C. Manrodt of Melbourne discussed cancer's seven danger signals at a meeting of employees of the Bank of Melbourne and Trust Company late in March.

Dr. T. D. Sandberg of Coral Gables has returned from Washington, D. C., where he attended the annual meeting of the American Academy of General Practice.

Dr. Walter C. Payne Sr. of Pensacola discussed "Health Insurance" at a March meeting of the Woman's Auxiliary to the Escambia County Medical Society held at the Pensacola Yacht Club.

Dr. Henry P. Bevis of Arcadia attended the annual meeting of the American Academy of General Practice held recently at Washington, D. C.

Dr. Theodore J. Kaminski of Melbourne outlined the progress being made against cancer in an address delivered at an April meeting of the Kiwanis Club of that city. Dr. Kaminski had returned earlier from Washington, D. C., where he was one of the physicians from Florida attending the annual meeting of the American Academy of General Practice.

Dr. Paul Plotkin of Miami Beach was principal speaker at an April meeting of the Greater Miami Multiple Sclerosis Association.

Dr. Clifton A. Young of Dunedin is taking a three months' postgraduate course at the New York Polyclinic Medical School and Hospital.

Dr. Elmer R. Conrad of Fort Lauderdale discussed hypertension at an April meeting of the Licensed Practical Nurses Association held in the City Hall there.

Dr. Albert E. McQuagge of Marianna has returned from Washington, D. C., where he attended the annual meeting of the American Academy of General Practice.

Dr. Jere W. Annis of Lakeland was principal speaker at an early April meeting of District 12, Florida State Nurses Association, held in the nurses home at Morrell Hospital. Dr. Annis discussed the care of the cardiac patient.

Dr. Robert L. Neil of Clearwater was in Washington, D. C. recently where he attended the annual meeting of the American Academy of General Practice.

Dr. Eugene L. Jewett of Orlando presented a paper on the subject "Fractures of the Hip" at the southeastern regional meeting of the United States Section, International College of Surgeons, held at Chattanooga, Tenn., the last of April and the first of May.

(Continued on Page 1042)

IMPORTANT RESEARCH CONTRIBUTION

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PROTEOGENIC EFFECTIVENESS • The newest Searle Research development, Nilevar, exerts a potent force in protein anabolism. Yet it is without appreciable androgenic effect (approximately one-sixteenth of that exerted by the androgens).

Investigations with Nilevar show that nitrogen, potassium and phosphorus are retained in ratios indicating protein anabolism. Nilevar is thus the first steroid which is primarily anabolic and which provides a practical means of meeting the numerous demands for protein synthesis.

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6. **Domiciliary care of decubitus ulcers.**
7. **Care of premature infants.**



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*McLester, J. S., and Darby, W. J.: Nutrition and Diet in Health and Disease, ed. 6, Phila., Saunders, 1952, p. 195.

(Continued from page 1034)

Dr. Shaler Richardson of Jacksonville is one of 12 ophthalmologists throughout the nation who will serve on committees to select recipients for the Residency Fellowships in Ophthalmology recently established by the Guild of Prescription Opticians of America.

Dr. Simon D. Doff of Jacksonville has been elected president of the Florida Trudeau Society. Serving with Dr. Doff is Dr. Howard M. DuBose of Lakeland as vice president and Dr. Kip G. Kelso of Vero Beach as secretary.

Drs. Samuel J. Alford Jr., Raymond R. Killinger and Leo M. Wachtel Jr. of Jacksonville attended the scientific assembly of the American Academy of General Practice held recently in Washington. Dr. Wachtel also attended the Invitational Scientific Congress of the Academy held at Miami Beach and was guest speaker at the banquet. His topic was "A Backward Glance at General Practice."

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*Moyer, J. H., and Hughes, W. M.: J. Chron. Dis. 2:678, 1955.

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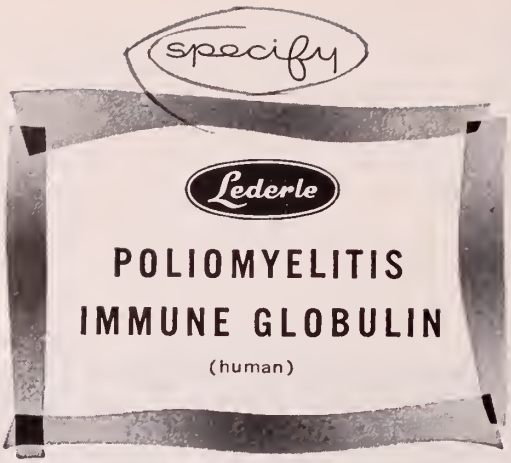
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1. Seifter, J., et al.: To be published. 2. Fazekas, J.F., et al.: M. Ann. District of Columbia 25:67 (Feb.) 1956. 3. Mitchell, E.H.: J.A.M.A. In press.

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*Fishberg, A. M.: Hypertension and Nephritis, ed. 5, Philadelphia, Lea & Febiger, 1954, pp. 177-178.

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National Convention This Month in Chicago

Delegates from the Woman's Auxiliary to the Florida Medical Association and the President, Mrs. Scottie J. Wilson have refurbished their summer bonnets in order to carry on the tradition of hat wearing prevalent throughout the northern states when they leave our sunny state for Chicago to attend the National Convention of the Woman's Auxiliary to the American Medical Association.

Florida has added another delegate to her growing list and this year will have 18 delegates and their presidential delegate to answer the roll call at the opening session of the business meetings. Having Florida announce a 100 per cent present delegation has become a tradition and I hope this year will be no exception.

Registration of delegates and members of the Auxiliary will start at noon, Sunday, June 10, and continue until noon, Thursday, June 14. Committee meetings will start Saturday, June 9, and Sunday, June 10, will also be devoted to committee meetings. Round table discussions on Legislation, Organization, Newsletters, Public

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Relations, Today's Health and the American Medical Education Foundation will be held on Monday, the opening day of the convention. The afternoon of that day from 3:30 to 5:30, a tea honoring the national president, Mrs. Mason G. Lawson and the national president-elect, Mrs. Robert Flanders, will be given.

Business sessions will be held all of Tuesday, June 12, from 9:00 to 5:00. Officers and Western Region states will report at the morning session. This will be followed by a luncheon honoring the past presidents of the national auxiliary with Mr. Leonard E. Head, President of the Foundation for Economic Education, Inc., as guest speaker. His topic is "The Positive Approach to Combating Socialism." The Southern Region States of which Florida is one will report at the beginning of the afternoon session and Mrs. Scottie J. Wilson will give the report for the 1955-56 year which was lead by Mrs. Samuel S. Lombardo as president of the Florida Auxiliary. Standing committee reports will also be given at the afternoon session and the election of the 1957 nominating committee will take place.

The business session on Wednesday morning will follow approximately this same pattern with further officers and chairmen reporting. At noon Wednesday, June 13, a luncheon will be held honoring the national president and national president-elect at which time Dr. Elmer Hess, President, American Medical Association, will be guest speaker. The Board of Trustees, officers, the secretary and general manager and assistant secretary of the American Medical Association will be the guests of the Auxiliary at this luncheon.

Wednesday afternoon will be devoted to round table discussions on Civil Defense, Program, Mental Health and Nurse Recruitment. Mrs. Richard F. Stover, chairman, will moderate the round table on Mental Health. The final business session of the Auxiliary will be held on Thursday morning at the Conrad Hilton Hotel, headquarters for the Auxiliary, and at this session, revisions will be read and discussed and passed on, the new officers for 1956-57 will be elected and the gavel will be handed from the out-going president to the new president who will then make her inaugural address.

The annual dinner of the Auxiliary will be held that evening at 7:30 with Miss Ilka Chase as guest speaker. Friday, the last day of the convention, will find the state presidents and presi-



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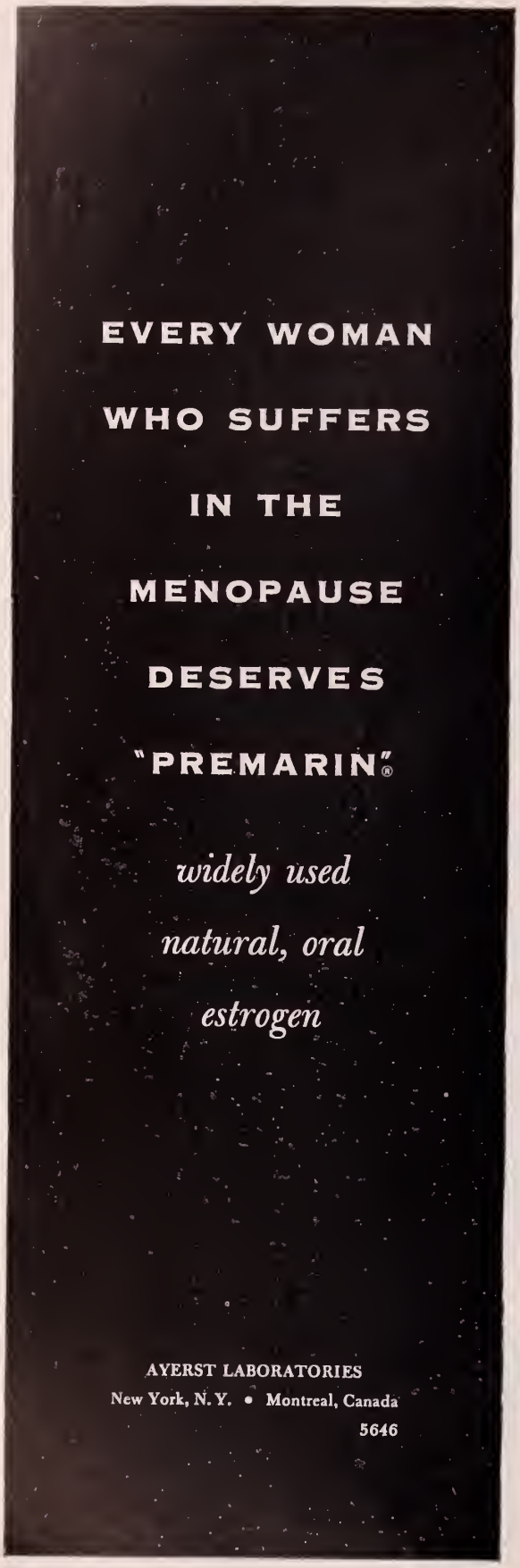
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dents-elect at a conference with committee chairmen, officers and directors of the national auxiliary. This is the final event of the convention which closes at noon, June 15.

After the five strenuous days of sitting in meetings, attending luncheons and talking with our friends and new acquaintances, I believe that those of us who are there will come home with hats that need re-refurbishing. But then why worry, living in Florida we can put them away in a hat box and forget them until we go to the convention in New York in 1957.

MRS. RICHARD F. STOVER

BOOKS RECEIVED

Planning New Institutional Facilities for Long-Term Care. By Edna E. Nicholson. Pp. 358. Price, $4.50. New York, G. P. Putnam's Sons, 1956.

The purpose of this book is to offer seasoned advice and assistance to the planners, administrators, operators and proprietors of nursing homes and to the management personnel of other institutions caring for long-term and chronic patients. The material presented is made possible as a result of a 10 year study conducted by the Institute of Medicine of Chicago in which the author, the Executive Director of the Institute, participated.

"This book could hardly be more timely," wrote Surgeon General Leonard A. Scheele in a foreword. "The rapidly growing interest in the leading health problem of the mid-century—chronic illness—has reached such a point that in many localities the desire to do something about the situation is forging ahead of the knowledge on which to base appropriate action. . . . Miss Nicholson's book is a happy blending of a deeply felt philosophy of care for the chronically ill, together with a comprehensive guide to the practicalities of planning the physical facilities to provide long-term care. It will serve individuals, organizations, and communities in their efforts to establish high standards of service to those who suffer from chronic illness."

Other forewords by Dr. Edwin L. Crosby, Director, American Hospital Association, G. Warfield Hobbs III, Chairman, National Committee on the Aging of the National Social Welfare Assembly, and Edwin B. Morris Jr., Director, Department of Professional Relations, American Institute of Architects, likewise commend the book highly as both stimulating and practical.

Tea—A Symposium on the Pharmacology and the Physiologic and Psychologic Effects of Tea. Edited by Henry J. Klaunberg, Ph.D. Pp. 64. Price, $1.00. Washington 7, D.C., The Biological Sciences Foundation, Ltd., 1955.

Tea, next to water, is the most consumed beverage in the world. Hundreds of papers and many books have been published dealing with the historical, technical, botanical, chemical, pharmacologic and medical aspects of tea since Lu Yu wrote the Ch'a Ching, or "Tea Scripture" in 780 A.D. Nevertheless, no serious effort has heretofore been made to organize the research and clinical literature on this subject for practical usage by individuals and organizations having a professional interest in human nutrition and physical fitness.

The papers presented here were included in a conference at the New York Academy of Sciences on May 16, 1955, sponsored by The Biological Sciences Foundation, Ltd., Washington, D.C. They were selected for the purpose of beginning an organization of research and clinical data on tea that will prove helpful to dietitians, nutritionists, the medical profession in general.



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When breast milk is not available, Pelargon makes an unexcelled substitute—conforming with latest pediatric knowledge. No supplementation is necessary, since Pelargon provides adequate amounts of all known protective vitamins (including vitamin C) as well as minerals.

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Lactose	23.5%	3.7%
Dextrins-maltose (from corn and barley malt)	12.5	2.0
Sugar (sucrose)	12.5	2.0
Starch, precooked (corn)	8.5	1.4
Lactic Acid	2.2	0.4
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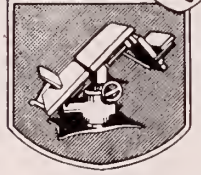
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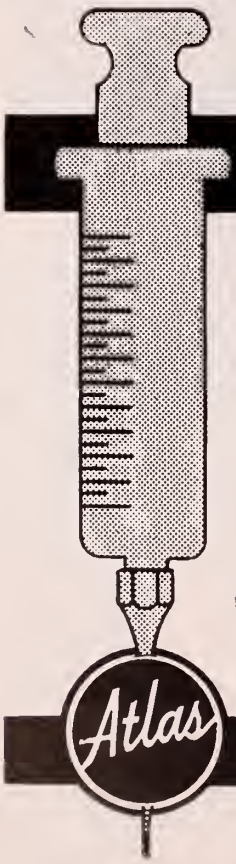
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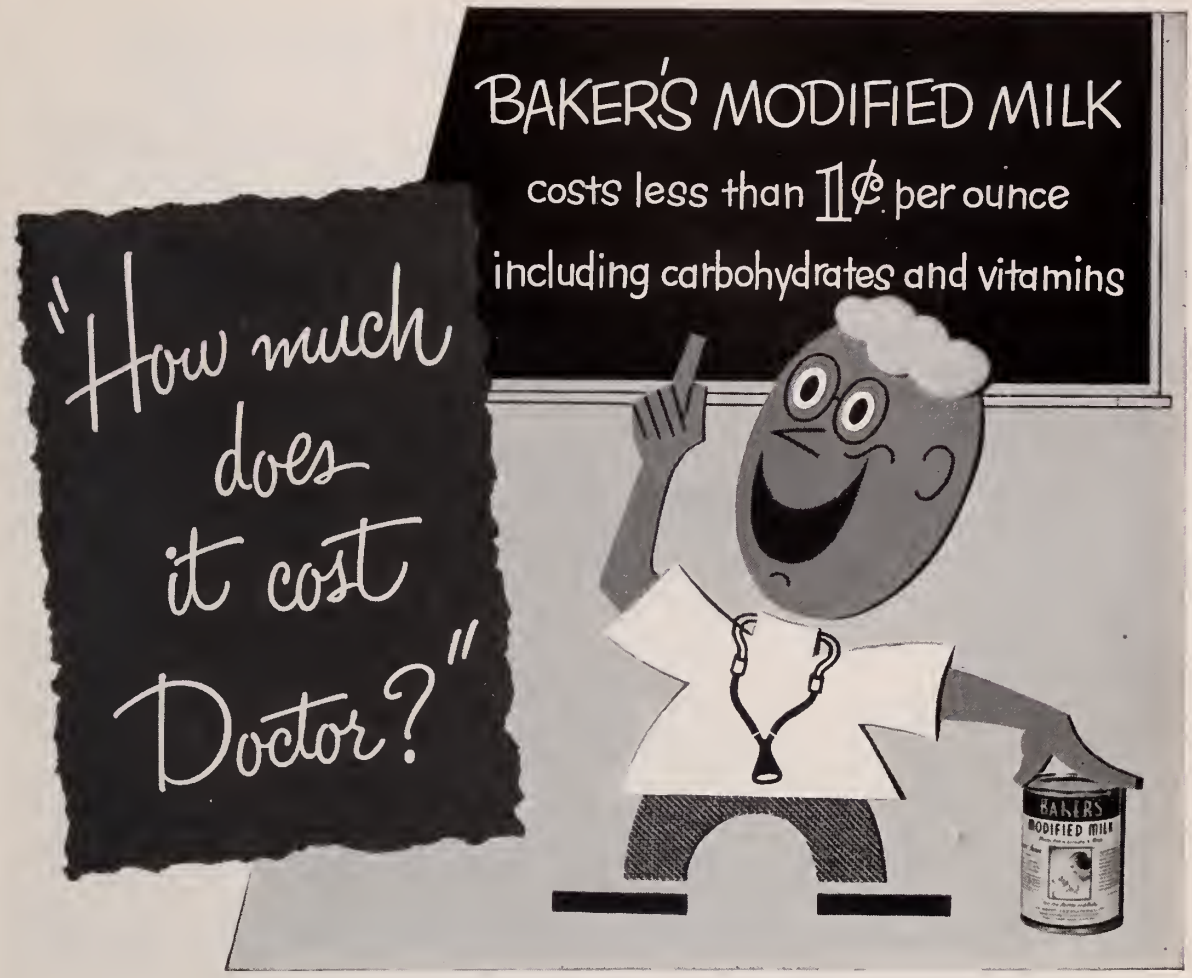
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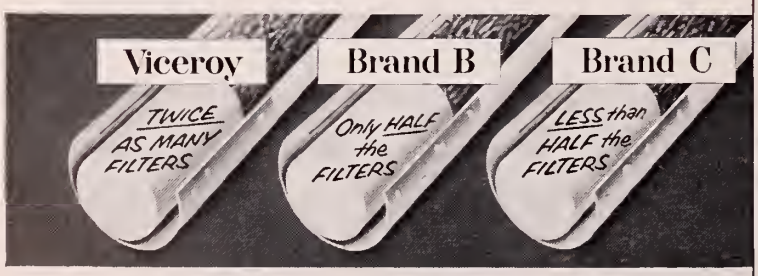


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1. Johnston, T. G., and Cazort, A. G.: J. Allergy 27:90, 1956. 2. Schwartz, E.: New York J. Med. 56:570, 1956. 3. Schiller, I. W., et al.: J. Allergy 27:96, 1956.

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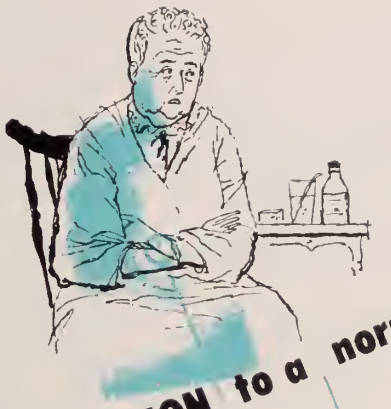
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1. *Levy, S.* J.A.M.A. *153:1260, 1953.*
2. *Thompson, Lloyd & Proctor, Rich* N. C. State, *Dec. 54*
3. *Thompson & Proctor,* Clinical Med *April, 1956*

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1. Cronheim, G., and Toekes, I. M.: Comparison of Sedative Properties of Single Alkaloids of Rauwolfia and Their Mixtures, Meet. Am. Soc. Pharmacol. & Exper. Therap., Iowa City, Iowa, Sept. 5, 1955.

2. Moyer, J. H.; Dennis, E., and Ford, R.. Drug Therapy (Rauwolfia) of Hypertension. II. A Comparative Study of Different Extracts of Rauwolfia When Each Is Used Alone (Orally) for Therapy of Ambulatory Patients with Hypertension, A.M.A. Arch. Int. Med. *96*:530 (Oct.) 1955.

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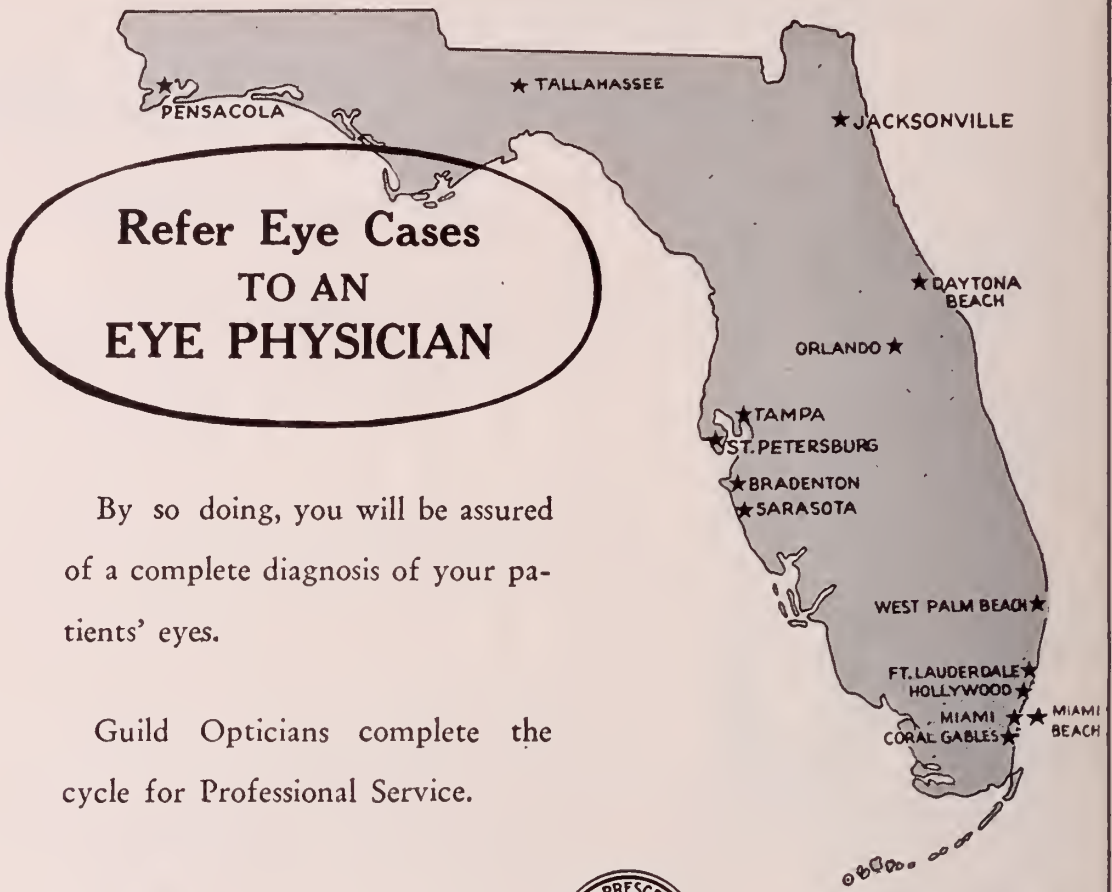
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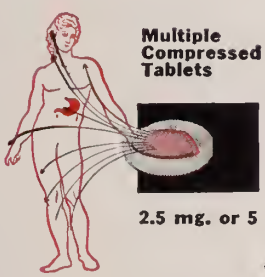
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References: 1. Boland, E. W., *J.A.M.A.* 160:613, February 25, 1956. 2. Margolis, H. M., *et al.*, *J.A.M.A.* 158:454, June 11, 1955. 3. Bollet, A. J., *et al.*, *J.A.M.A.* 158:459, June 11, 1955.

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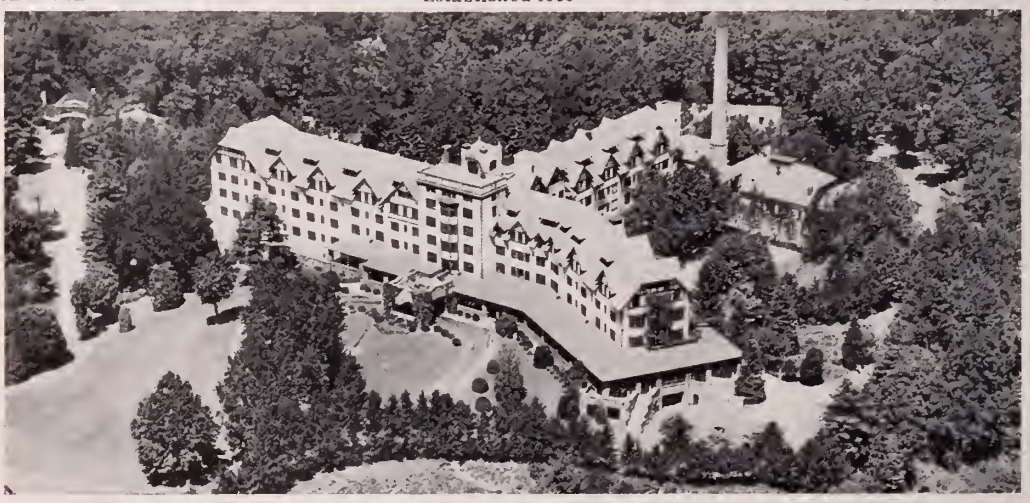
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Dade	Hunter B. Rogers, Miami	Vincent P. Corso, Miami	1st Tues.	752
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**Escambia* Santa Rosa*	Gretchen V. Squires, Pensacola	Pascal G. Batson Jr., Pensacola	2nd Tues.	106
Franklin-Gulf	Harold B. Canning, Wewahitchka	Photis J. Nichols, Apalachicola	Last Wed.	6
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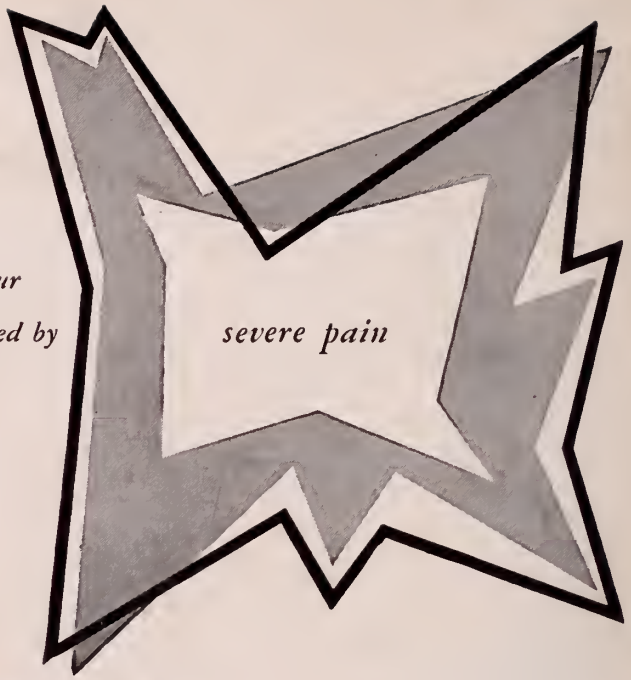
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1. Karp, M., et al.: Am. J. Obst. & Gynec. 69:780 (April) 1955.

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